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THE SOCIAL WORKER IN A HOSPITAL WARD

THE SOCIAL WORKER IN A HOSPITAL WARD

BY
ELSIE WULKOP

WITH COMMENT BY
RICHARD C. CABOT, M.D.

BOSTON AND NEW YORK
HOUGHTON MIFFLIN COMPANY
The Riverside Press Cambridge
1926

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The Riverside Press

CAMBRIDGE · MASSACHUSETTS

PRINTED IN THE U.S.A.

W96
1926

ACKNOWLEDGMENTS

THE author's thanks are due to many persons: to her colleagues whose work has furnished the case histories; to several persons who have made valuable criticisms of the manuscript; to Miss Ida M. Cannon and Dr. Richard C. Cabot for their encouragement and inspiration, no less than for their direct contributions; and finally to the donor of the money which has made possible the compilation of this book.

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FOREWORD

'I CAME to see just what you are doing in the Social Service Department. May I read some of your records or go around with one of the members of the Department?' But social work in a big human institution like the Massachusetts General Hospital cannot be shown by guides as one would show processes in a factory. Nor can a visitor, no matter how welcome, be turned loose in our record file. Most of those histories are confidential and all are carefully safeguarded. And no visitor, no matter how sympathetic, can share the interviews between the social worker and the patient. Yet we do wish to share our experience with others who are working out the interrelations of Medicine and Social Work.

There is no standard procedure. There *are* underlying principles. Some of these are found everywhere in the best social case work. Others have evolved out of the experience of those who, during the past twenty years, have been helping to develop the art of social work in its application to scientific medical practice. Because medical social work is an art, it is modified inevitably by the practitioner of the art. In this book Miss Elsie Wulkop, who for years has been a member of the staff of the Social Service Department at the Massachusetts General Hospital, shares with the reader her experience and her methods. The incidents in the records are true. The details are modified to disguise the individual case sufficiently to avoid identification.

Dr. Cabot's running comments and general comments at the end of the series of case histories are characteristically stimulating and challenging. This is especially in keeping with our days' work, for through the years that we have been working at the Massachusetts General Hospital, we have had this same frank, whole-hearted give-and-take of opposing opinions

and hearty appreciation that we are now offering to a wider circle.

The purpose of this book will best be fulfilled if students of hospital social work find here, not necessarily ideas or methods with which they agree, but material for thoughtful study and discussion. The general principle of social service as a part of medical practice is very generally accepted. But art in the practice of social work in medicine can never be standardized. It is too involved in the vital, pulsating life with which it is concerned. The development of the art is in the hands of those who have the privilege of daily contact with the patients — the case worker, not the executive. This book is offered especially to case workers in hospital social service in the hope that it may help them to get a perspective on their days' work.

The generous donor who has given the funds for freeing Miss Wulkop to work on this book chooses to remain anonymous even to me. But I wish here to make public acknowledgment of our appreciation of his generosity, his faith in leaving us entirely free to use the money for anything that would further the purposes of hospital social service.

IDA M. CANNON, *Chief of Staff*
Social Service Department
Massachusetts General Hospital

PART I

INTRODUCTORY

THE SOCIAL WORKER IN A HOSPITAL WARD

INTRODUCTORY

THE MATERIAL USED

THE work described in this book was carried out at the Massachusetts General Hospital, a private hospital, receiving no aid from city or State, and serving patients from all over New England and even from Canada. The hospital ministers to persons of all the social groups and of all the medical groups; for while there are some diseased conditions for the treatment of which patients are not admitted, yet these same conditions do occur in patients already under treatment for other reasons. Hence the social work carried on in connection with our patients covers practically the entire medical-social field.

The following series of cases has been chosen because of significant medical and social factors. Though grouped by diagnoses, it will appear that every type of social problem is to be found in connection with any disease. Nevertheless certain types of social problems have been sought for presentation, others omitted, because much has already been written on some phases of social work. The psychiatric field has been well covered; work with children has been ably reported; correctional work with delinquents has had excellent presentation; sex problems have been carefully studied. For this reason these groups are not considered here, although they figure largely in the work of the Social Service Staff at the Massachusetts General Hospital. This selective policy involves sacrificing in this book certain dramatic qualities inherent in the problems which belong to the omitted groups. In the choice

of these illustrative cases, a considerable degree of selection has been necessary, although they are not unique examples of particular problems. Medically these histories are here transcribed without alteration; socially changes have been made in the identifying data, but not in the problems. Great care has been used in order that the essentials remain untouched; no patient has been removed from his racial background; his economic and social status is unaltered; such facts as have been eliminated have been replaced by others believed to be socially equivalent. The aim has been to put each problem before the reader essentially as it was faced by the social worker.

Each history has been analyzed according to a schedule explained at the beginning of the series. The analysis falls into two divisions, (1) the facts known to the social worker when she began treatment, and (2) those which she secured as the case progressed. For purposes of ready comparison of the medical and social items, they have been arranged in parallel columns irrespective of the time element. The medical facts indicate the amount and kind of medical knowledge which the case worker must have when she begins her work with each patient. Unless she has these facts clearly in mind she will waste time and make errors in treatment. Of course there may be additional medical history which she may acquire later; the possibility of there being such additional information must be borne in mind from the beginning, else it may be overlooked.

The purpose of presenting this analysis at the outset of each case is to show what facts the case worker started with and what others (not emphasized in the narrative and comment) are important. The narrative is focussed on the crisis of the particular history. The comment speaks for itself.

As for the identity of the social workers, each name stands for a definite individual. When the narrative is told in the first person, several different persons are included under 'I.' There is no ulterior motive for this dual plan of presentation;

some of the histories lent themselves better to one form, some to the other.

The book does not pretend to do more than indicate what medical-social case work is. It is not possible to teach the practice of this art through books unless they are supplemented by carefully supervised work in hospitals. The actual methods by which results are obtained must be learned at first hand from skilful social workers, and by practice.

SOME ASPECTS OF MEDICAL-SOCIAL WORK

Into our large hospitals pours daily a great stream of humanity. Its sources are infinitely varied, but the individuals who make up this stream, however much they differ among themselves, have this in common; they are ill and want help. Some are in worse plight than others, but all have some hope of relief, otherwise they would not be there.

The outgoing stream, however, is divided into two portions: those with hope and those without it. A hospital for acute disease, such as the Massachusetts General, cannot keep patients until health is wholly restored, or the story ended. What becomes of these patients after they leave the hospital walls? Surely someone should be at hand to stand by those for whom there is nothing more that Medicine can offer. Someone should see that the doctors' orders for supplementary treatment after discharge are understood and made possible of fulfilment. These are some of the responsibilities of the social worker privileged to serve in hospital wards.

Since the success of medical-social work depends largely upon the medical work with which it is correlated, the social worker cannot begin her own treatment until she has received the medical data from the physician in charge of her patient. She can, and often does, foresee the general nature of the treatment required; for instance, she knows that convalescent care will be needed after pneumonia. Nevertheless she does not choose the place where the patient is to convalesce until the doctor discusses the medical situation with her. Her first

line of inquiry is always the medical. She then secures her social information from the patient, the family, or whatever source is indicated. Sometimes the facts she learns contra-indicate the doctor's first plan. But she does not go against his advice. If she cannot convince him that the social situation demands the carrying out of her plan for that particular patient, she is probably wrong in her social judgment. As a matter of fact, it is difficult to imagine a situation where a physician thinks his social worker is needed, but where he so lacks faith in her judgment as to override the opinion for which he has asked. The social plan should be a matter of consultation, a merging of all three points of view — that of the patient, the doctor and the social worker.

The policy of bringing patients in touch with social workers varies in different hospitals according to their organization. One plan which has proved practical is to assign one or more social workers to a certain out-patient clinic or to certain medical or surgical wards. Thus each doctor comes to know the social worker assigned to assist him, to understand fairly accurately wherein she can help and wherein she is powerless. For the social worker the advantages of this plan are clear. Such a relationship is capable of bringing out the best that there is in medical and social practice and of focussing it on the common problems.

That these problems are often serious and distressing goes without saying. No one should work in a hospital who is not prepared to face human sorrow and despair in its most intense forms. Every patient who enters the wards is more or less distressed by what he sees and hears around him. His relatives, even his friends, share the anxiety attendant upon the illness of a member of the family away from home. Unless he is dangerously ill, they are allowed to see the patient only at stated hours. They learn from him all the bewildering processes to which he is subjected. Regardless of the fact that the patient was probably a long time sickening and will certainly be a long time recuperating, they hope against hope that a miraculous

cure will be made almost overnight. When prolonged care outside the hospital is advised by the doctors, the friends and family are often at a loss where this is to be obtained, even if they do know whence the money for it is to be drawn.

Of course, the financial problem is frequently a heartbreaking element in the situation. That a man will die unless he can have prolonged rest or a new job — which will probably bring him less income; that only sanatorium care can save this young mother's life; that this old woman and that young boy cannot die in comparative comfort unless money can be provided: hard facts such as these, in the face of poverty, are apt to drive the relatives to despair.

Into this complexity of sorrow, anxiety and despair the social worker is admitted either at the request of the physician, by her own volition, or through some other person who knows that she is needed there. What gives her her right to approach the sufferers? Primarily, her skill in solving the social problem, but secondarily, her sympathy, the courage or the consolation which she tries to bring. If she does not bring these, she has no place in medical-social work, no matter how great may be her proficiency in social case work in other fields.

If this sympathy is needed in her work with the relatives and friends, how much more essential it is when she tries to help the patient! To the latter she often seems, like himself, a bit detached from the medical and nursing routine and busy hospital life about him. She also is interested in what is to happen after he leaves the hospital, in his family while he is sick. To the patient, the fear of an operation, the hidden belief that he is not going to survive it, are almost inevitable. He longs to believe the physician or nurse who tells him that he is not going to die. But he cannot rid himself of the dread that for him nothing earthly lies beyond the first whiff of ether. In his struggles to maintain a respectable *sang-froid*, he often shuts himself off in silence. To such a soul, great is the relief with which he hears the social worker plan for his care after the operation. She enables his imagination to leap beyond the

awful days of danger to the safe period of convalescence. Many and many a patient who knows that he is to be transferred by way of the operating table from a medical ward with its familiar faces to a surgical ward where all are strangers, finds the most astonishing comfort in the promise of his social worker to *see him as soon as he is out of ether.* Clearly she is sure that he is coming out of ether in condition to know her. Well, then, perhaps the doctors and nurses do mean what they are saying, after all.

The social worker in this field needs a considerable knowledge of medicine, of the causes and symptoms of disease and of its treatment and of what constitutes good nursing. But she never suggests medical treatment, she does not try to make diagnoses, she respects the expertness and the ethics of the medical and nursing professions. If the social worker is to do justice to her own profession, she must not invade the field of the nurse. Medical-social work is not nursing any more than it is the practice of medicine. The patient profits most when he has the services of at least three persons — the doctor, the nurse, the social worker. Each must know, appreciate and utilize the special skill of the others and therefore respect his own limitations.

It is important to have a patient understand the social worker's relation to the physician. A step in this direction is taken when the physician consults the social worker in the presence of the patient, tells her what the medical situation is and asks her to find out the economic, domestic, industrial and psychological circumstances wherein the medical treatment will be carried out and by which it will be modified. From this interview the patient learns three things: first, that the social worker is a colleague of the physician, who trusts her judgment and asks her aid in treatment; second, that she is to make a social examination analogous to the physical one done by the doctor and that treatment is to be based upon facts gained from both kinds of examination; third, that the social worker has a recognized place in the medical organization of

the hospital and hence is invested to some extent with its authority. If, in addition to these three points, the patient also realizes that the doctor and the social worker often meet to discuss and to arrange some modification of treatment, the social worker is established in the patient's confidence as part of the agency by which he hopes to regain, or at least to improve, his health.

For certain cases of cardiac disease and for practically all cases of tuberculosis, the right kind of institutional care after leaving the hospital is important. The advantages of this care may be summed up as follows: close medical supervision during the period when the patient is increasing his activities, the inspiration which almost always comes from group treatment, the drill in hygiene until it becomes automatic, the longer period — usually from two to four months — which the family have for making the necessary rearrangements. If the social responsibility has not been transferred to someone else, the hospital case worker should keep in touch with her patients while they are in such institutions. If possible she should visit them, at all events she should write, not with regularity but with an endeavor to break the monotony of the patient's long days, and with as much spontaneity as possible. Social treatment, consisting largely in suggestion, teaching, encouraging and advising, can often be well carried out by letters if these are carefully thought out and clearly expressed.

Letters of advice and encouragement are helpful to patients who are continuing treatment in their own homes, but who live at such a distance that visits by the social worker are impossible or infrequent. The patient's letters in reply are often illuminating, throwing light on his mental processes, his educational background, and his emotional states. Indeed I believe that the social worker might well elicit at least one letter from every patient under treatment, and no matter how little importance it may seem to possess, preserve this letter in the record.

A point often lost sight of by the medical-social worker is

the necessity for keeping in proper perspective all the factors in the patient's problem. It is easy to concentrate one's attention upon the medical aspect of the case. It is usually in the forefront of the patient's mind. The doctor and nurse are focussing on this. Important as this is, it is not the only thing to consider when making plans for the patient. In these days a tendency to overemphasize health is becoming more and more apparent; but what is not so obvious is the frequent result of this emphasis. There is danger of sacrificing such things as proper recreation, further education and other legitimate needs of various members of the family. One might go even further and speak of the destruction of spiritual values, the inculcation of a pagan passion for life at any cost. Granting that health is the foundation for full wholesome life, one must recognize that it *is* the foundation and that the superstructure which it supports is the vital thing.

It is especially important that the social worker who almost alone in the medical institution is concerned with the social situation, should strive to give due weight to all the factors.

Another fundamental question which is in the mind of social workers is that of social prognosis. Are we developing any ability to forecast the probable outcome of our efforts along any given line? Do we really profit by experience or do we begin all over again with each case? In other words, is social prognosis becoming a part of our case work? There is small reason to hope that we can ever reduce this even to the approximate accuracy of medical prognosis but somehow the attempt must be made since it entails clearer thinking.

In an age which is accustomed to an increasing degree of analysis of all processes it is idle to expect that social work will not be thus challenged. Just as in medicine, the best way to make progress in social work is through thoughtful analysis and interpretation of the fruits of experience.

PART II

CASES

CASES

CASES are analyzed according to the following, except that whenever any of these items are not pertinent to a case, they are omitted:

MEDICAL SOCIAL PROBLEM

1. MEDICAL-SOCIAL DATA

Medical
(Patient)

a. Diagnosis
b. Prognosis
c. Treatment
d. Additional medical history secured by social worker

Social
(Family and patient)

a. Analysis
   1) Racial background
   2) Past history
   3) Economic status
   4) Legal status
   5) Health
   6) Education
   7) Work
   8) Character
b. Treatment (plan and results)
c. Sources of information

2. THERAPEUTIC ASSETS

Medical

a. L.M.D.
b. Hospitals
c. Nursing homes
d. Convalescent homes
e. District nurse

Social

a. Family and patient
b. Relatives
c. Benevolent individuals
d. Private agencies and institutions
e. Public agencies and institutions

NARRATIVE

COMMENT

EXPLANATORY NOTES

D.L. Danger List. Patients who are critically ill are put on this list; their relatives are notified at once of this fact. Such patients have the privilege of having two visitors constantly with them.

Free bed. An endowed bed, the occupant of which is designated by the donor or his deputy.

H.O. House Officers. Hospital internes.

House Social Service. Division of the department which cares for patients in the wards.

L.M.D. Local doctor of medicine.

M.G.H. Massachusetts General Hospital. Because of the lengthy title, the hospital is known locally to many persons by its initials.

Mothers' Aid. A grant from the State of Massachusetts which is administered by the Department of Public Welfare. As its name implies the aid is no limited to widows, but may under certain conditions be given to other married women. Families in receipt of this form of aid are under the supervision of social workers.

Nursing Home. Private homes owned by nurses who give various degrees of nursing care. The homes used by the Social Service Department are all investigated. If they do not continue to meet the standards of the Department, they are not patronized. The rates are from about $12 a week, for simple convalescent care, to $50 or $60 a week for cases requiring private rooms with specially close attention. Excellent care in small wards is available at a charge of $18 to $25 a week. Such homes are indispensable. They originate through private initiative, but might readily be developed in response to a demand from a hospital through its Social Service Department.

O.P.D. Out-Patient Department. Again, the initials are used for the sake of brevity.

Overseers of the Poor, or of Public Welfare. Officials of the local governments who are charged with the disbursement of public funds for the relief of the indigent. Admission to certain institutions is controlled by them.

Settlement. Massachusetts has a number of laws regulating the resident's eligibility for receipt of public aid, both in and out of institutions. Put very briefly, a settlement is five consecutive years of residence in a specific town or city without the receipt of public aid during the period. It is not dependent upon citizenship. Settlement may be broken locally, but still hold good for the State at large.

HEART DISEASE

(Eight cases)

SUMMARY

Case 1. *Mary Edwards:* æt. 11.
Rheumatic heart disease with chorea; institutional care; insufficient income; unfavorable home environment.

Case 2. *Dennis McDougal:* æt. 14.
Rheumatic heart disease; home care; meagre income; father dead. Bad prognosis belied by course of events.

Case 3. *Morris Simofski:* æt. 15.
Rheumatic heart disease; unsuitable home; foster-home care.

Case 4. *Marie Franck:* æt. 15.
Rheumatic heart disease with acute rheumatic fever; institutional care.

Case 5. *Esther McAdam:* æt. 26.
Rheumatic heart disease; home and institutional care; inadequate income; probable dependency.

Case 6. *Edith Jenkins:* æt. 46.
Angina pectoris; leg amputated after an accident; estrangement from relatives; no financial resources except her own earnings.

Case 7. *Arturo Martini:* æt. 41.
Syphilis of heart; infection communicated to family; dependency on public support.

Case 8. *James Morton:* æt. 50.
Arterio-sclerotic heart disease; chronic alcoholism; very meagre income earned by wife.

NOTE ON SOCIAL WORK IN CASES OF HEART DISEASE

In all social case work the keynote of technique is flexibility, and nowhere is this attitude more imperative than in work with cardiacs. The method employed by the social worker in her treatment of patients with heart disease does not differ in kind from that which is used with any other group of patients, but in degree it differs essentially. More detailed care must be lavished on the former, more attention given to analysis of their characters, greater caution employed in what in other cases might seem minor matters, for their condition is often precarious to an extent presented by few other sufferers. Consequently poor social work is the more likely to bring forth immediate disaster. If transportation to the clinic is not provided for the serious cases, if patients are not warned of the peril of cold, windy days, if frequent periods of rest and food between meals are not suggested to those exposed to fatigue, if alarm and discouragement are not promptly dealt with, and if many another minor matter is not taken into consideration, then the most skilled medical treatment and the most thorough attention to the outstanding social problems will fail to bring their full benefit or to accomplish the desired results.

CASE 1

MARY EDWARDS Age 11 *Single*

Admitted to ward September 29, 1920. Discharged November 2, 1920.

MEDICAL SOCIAL PROBLEM

Chorea with rheumatic heart disease; insufficient income; unfavorable home environment.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis*
Chorea; question of endocarditis.

b. *Prognosis:*
Favorable.

c. *Treatment:*
Hospital care until chorea has disappeared; thereafter some weeks of convalescent care and then supervision at home long enough to prevent a relapse.

d. *Additional medical history secured by social worker:*
Patient had scarlet fever four years ago.

Social
(Family and patient)

a. *Analysis:*
Father is of English stock, mother of Irish; both are natives of the United States and are Roman Catholics. Children were all born in town where family now lives. Family life has been rather uneventful and has been conditioned by the meagre income earned by father in factories. Three older children have worked after school at such things as running errands, helping neighbors in care of children, etc. Legal status is that of native citizens with a settlement in town of residence. Health of mother and children has not been good for the past three or four years. Education of parents is only fair, but they wish to send children through high school. Children are doing fairly well in grades normal to their ages. Father has a very good reputation, is devoted to family; he is intelligent and readily accepts advice given even when this implies a radical change in his own attitude toward health of children. Mother is warm-hearted, impulsive, affectionate, very loyal

Medical (Patient only)	*Social* (Family and patient)
	to all obligations, easily guided toward change of habits, discipline, etc., but lacks power of conserving her own energy. Has high ideals for children, but is not foolish in trying to obtain the thing which is beyond them. Children are all intelligent and affectionate, with no character defects beyond ordinary childish ones susceptible of correction.
	b. *Treatment:*
	1. *Plan:* Place patient in an environment suitable to convalescence after discharge from hospital. Arrange medical treatment for family as indicated; report to social agency in home town.
	2. *Results:* Supervision over four years with medical treatment for mother and five children. Social treatment for every member of family; health of group brought up to a satisfactory level. Family life strengthened; development of children guided.
	c. *Sources of information:* Other agencies; schools.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.:* Is available, but he prefers to have hospital take over the treatment of the family.	a. *Family and patient:* Family will coöperate in every way. Patient's own attitude is good.
b. *Hospitals:* Acute and chronic hospital care may be had.	b. *Relatives:* No relatives who are able to help.
c. *Nursing homes:* Are too expensive.	c. *Benevolent individual:* No benevolent individual is interested.
d. *Convalescent homes:* Are not suitable.	d. *Private agencies and institutions:* Are available.
e. *District nurse:* May be called in if necessary.	e. *Public agencies and institutions:* Are also available, but are not needed.

NARRATIVE

Mary Edwards was sent into the ward at the M.G.H. by a charitable agency in the town in which she lived, some forty miles from Boston. A local physician had visited the child at the request of this agency and had recommended hospital care because Mrs. Edwards was not equipped by nature or education to care properly for Mary; nor were the home surroundings favorable to her, for she had two sisters and two brothers, all of whom were lively young individualists. Their mother's attempt to control them led to much dissension and turmoil.

The home, which was being bought through a coöperative bank at the rate of $20 a month, was a very comfortable seven-room frame house which had a good bathroom, electric lights and a piazza. There was a garden of considerable size. Vegetables, chickens, even a pig, were raised by the family. This was good for the family exchequer, but bad for the mother, who necessarily performed most of the work involved. Mrs. Edwards was a good mother with sound fundamental principles of home-making, but she lacked executive ability; her work piled up on her; she could not wisely apportion her husband's wages of thirty dollars a week; she constantly attempted to do more than time and strength permitted — she rarely knew when to say no to her children's demands.

At the time of Mary's admission to the ward, Mrs. Edwards was examined at her own desire in the Out-Patient Department, where she was told that she needed an operation and ought to have it at once. She would not consider it at that time because of inability to leave her family. Miss Carrington, social worker in the ward, therefore communicated with the secretary of the local society about the entire situation, with the result that arrangements were made for Mrs. Edwards to come into the wards for her operation while Mary was still there.

Both patients got on well. Mary showed marked improvement under treatment, which included the removal of her ton-

sils and some teeth which were beyond repair. When she was ready for discharge, Miss Carrington reported to the local agency that the doctors recommended about a month's convalescent care away from home, which was arranged by the local society. Later, when Mrs. Edwards was discharged from the ward, she was sent to the same home. The woman in whose care they were had had much experience in the care of the sick, but she was not prepared to give in any sense the equivalent of what a nursing home or a convalescent home could give.

Soon after, Jennie, the oldest girl, was brought into the Out-Patient Department because the school physician thought that she had something wrong with her heart. It was while seeking for a possible cause of rheumatic heart disease in Jennie and chorea in Mary that it was learned that all four children had had scarlet fever a few years before and had not seemed in good health since. The examination at the Cardiac Clinic showed that Jennie's heart was of a definitely rheumatic type; the doctor recommended that Jennie report every month at the clinic for observation. She was told to omit all violent exercise, but was allowed to continue with some work which she was doing for a neighbor after school hours.

Miss Carrington talked over the situation with Mr. and Mrs. Edwards explaining in detail what Jennie and Mary needed. She also laid emphasis on Mrs. Edwards's condition and the necessity of being very careful for at least six months because of her operation. Mr. Edwards was a large, healthy man who had never been ill in his life, and he consequently had some difficulty in comprehending why so many restrictions and precautions were necessary, but he was intelligent and open to conviction that for his family an easy-going attitude toward health was not wise.

Mrs. Edwards and the two children reported at the Out-Patient Department one month after Jennie's first visit and were found to be in good condition. Mary was so greatly improved that her physician said she might return to school in

one more month; her heart showed practically no damage and the chorea had disappeared. She was to report at the clinic in from three to six months according to her condition. Jennie was given the same instructions about coming to the clinic. For both children the physicians laid emphasis on prevention of the neurotic symptoms which so often develop in children who know that there is a question of their having heart disease, and, of course, the importance of avoiding acute infections was stressed. These directions were very carefully explained by Miss Carrington to the parents and to the secretary of the local social agency.

During the next few months nothing was heard from the family until Miss Carrington wrote a friendly letter to Mrs. Edwards inquiring how the intense cold weather had affected them. To this letter Mr. Edwards replied saying that Mrs. Edwards, Jennie, Mary, and Harry, the third child, had all been ill. Miss Carrington gathered from Mr. Edwards's description that Mrs. Edwards was simply worn out, that Mary's chorea had recurred, that Jennie's heart was troublesome and Harry had 'rheumatism.' She therefore wrote at once to the secretary of the charitable society asking that the three children and Mrs. Edwards be brought to the clinic. A few lines to the same effect were also sent to Mrs. Edwards.

When Mrs. Edwards and the three children, accompanied by the secretary, appeared at the Hospital a few days later, the secretary said that she had not been aware of the renewed illness, as the school nurse had been supervising. She talked over future plans with Miss Carrington and left the entire responsibility to the latter.

After the physicians finished their examination, Mary and Harry were immediately sent into the wards. Mrs. Edwards was very much upset by the necessity for this, although somewhat consoled by Jennie's good condition which allowed her to resume normal activities. The task of reconciling Mary and Harry to entering the wards was not easy. Eleven- and eight-year-old children can frequently impose their own will on

their mother, especially if they are cleverer than she. Mrs. Edwards, however, reënforced her authority with Miss Carrington's and finally left two weeping children to be escorted by the latter to the wards. There the tears lasted all afternoon.

Knowing that Mrs. Edwards might not be able to come to Boston soon again, Miss Carrington discussed with her the future plans for Mary and Harry; she advised that both of them be cared for in Boston for a while after discharge from the Hospital, since it was evident that Mary could not make a thorough recovery at home. Mrs. Edwards gave Miss Carrington authority to make any arrangements which the doctors recommended; she admitted that home was evidently not the best place for the children and that neither Mary nor Harry had been physically up to the extra work which they had been doing after school, though she and her husband had not thought that running errands for a local shop could harm them. Loyal wife that she was, Mrs. Edwards assumed her full share of responsibility for what Miss Carrington strongly suspected was Mr. Edwards's opinion, not hers.

Next day, after Miss Carrington was sure that Mary and Harry were settling down contentedly, she wrote to Mr. and Mrs. Edwards to reassure them and also to give them in a written form detailed medical information on all three of the children. Her next step was consultation with the children's physicians relative to sending them to Mercy Hospital when they were ready for discharge. As this plan met with the doctors' approval, Miss Carrington applied for their admission. In due season both Harry and Mary were transferred from the M.G.H. to Mercy Hospital, where they spent a little more than three months. They were away from home over four months in all and were greatly improved in health by this prolonged hospital treatment. Harry's tonsils were taken out and both children had dental work done. The social treatment during this period consisted of close contact with both children, frequent letters to and occasional interviews with parents, arrangements to have both hospitals give free treat-

ment, special visiting arrangements, reports to the local society, and personal interviews with the school nurse. The latter had not been told hitherto of the complicated medical situation. She promised (and gave) close coöperation thereafter, but, as events turned out, her position was abolished soon after this because of lack of funds.

Six weeks after Harry and Mary returned home they were allowed to go back to school, as the examination in the Cardiac Clinic showed that they were in excellent condition. Miss Carrington had to talk to Mary, however, on the subject of her behavior at home, as Mrs. Edwards reported that Mary was inclined to refuse to do any household tasks on the score of her physical inability to make exertions. (See comments at end of book.) This attitude of Mary's was approached by Miss Carrington from two angles: first, she explained in simple language what effect chorea has on health, its possible relation to heart disease and how the prolonged hospital treatment had practically eliminated any permanent damage in her own case; and, second, the state of her mother's health was dwelt on, bringing out the contrast between her condition and that of her mother, who had worn herself to skin and bones in looking after her children. Mary was urged to do her best to be a cheerful and willing little daughter, eager to repay a little of the devotion she had received. The positive therapeutic value, both mental and physical, of a certain amount of housework was also brought out. Mary's reaction was good; she evidently had never thought of these things in just this way, but she promised to be more careful and considerate in the future.

For six months the family life ran smoothly, although Mrs. Edwards was not well. She came in occasionally to the Medical Clinic. The doctors said that she was thoroughly tired out; her gastric symptoms were really due to heart trouble, and she needed at least a month of rest after which she must have lighter home responsibilities. But she refused to consider any plan that involved her leaving home. So Miss Carrington did

what she could to carry out the other phases of the doctors' recommendations. The plan of the housework was gone over, eliminating some of it, transferring other portions to Mr. Edwards and the older children. Household appliances to lighten the work were given her. Extra milk for the entire family was supplied by the local society, which also gave Mrs. Edwards a comfortable couch so that she could lie down at intervals during her day's work without having to go upstairs. She was encouraged and reassured and made to feel that the physicians and social worker were deeply interested, and, above all, a month's rest was kept before her as the ultimate goal.

For the children necessary dental work was arranged through the coöperation of a dentist in their home town who gave his services. Their diet was carefully planned with especial attention to extra luncheons during school hours. The latter feature made such an impression on Mary's teacher that she had her entire class bring bread and butter to eat at three in the afternoon. The two younger children, Susan and George, were brought into the Out-Patient Department for examination, as Susan had the same history of scarlet fever and George could not seem to be brought up to par in matters of weight and nervous poise. Susan was found to be in good condition, although her heart had unmistakably been injured, probably by the scarlet fever. George needed careful supervision and a greatly simplified scheme of life. He was in the first grade at school; the doctors ordered attendance only in the morning, after which he was to spend the rest of the time in bed without occupation. Fresh air, sunlight, balanced diet were also strongly emphasized. The coöperation of the school was secured and supervision was given at the clinic until George was in much better condition.

The doctors' instructions for the various patients were faithfully carried out with real benefit, although it was not entirely easy to do this because Mr. Edwards had a period of unemployment just then due to the temporary closing of the factory where he worked. Actual money subsidy was not

given the family, as it was not welcome to Mr. and Mrs. Edwards, but other means were found of easing their burden through gifts of clothing and household supplies. Through all this time Mrs. Edwards's need of a rest was not lost sight of, but she could not be brought to consent to it, especially as Mary was showing some indications of rebelling at home discipline.

Miss Carrington was asked by Mr. and Mrs. Edwards to meet this situation, as they themselves did not feel equal to it. They specifically requested that Mary be given instructions in sex hygiene, as they were sure she needed it. On one occasion, when she was out without permission after dark with another girl and two boys, her mother had whipped her soundly. Miss Carrington told them frankly that she thought this unwise.

Miss Carrington bided her time for talking with Mary until one day she took her on a shopping expedition to spend some money raised for providing Mrs. Edwards with certain necessities. After luncheon, the subject which Miss Carrington wished to discuss came up quite naturally. Mary took the instruction so well that Miss Carrington was quite sure that the child was in no danger, although undoubtedly she had heard certain physiological facts commented upon in an undesirable manner. To Miss Carrington's explanation, given in simple medical terms, but with spiritual values also brought out, Mary listened attentively and responded sensibly. It may be added that this episode proved later on to have been productive of good, not only to Mary, but to other girls to whom she told what she had learned at 'our hospital.'

It was not long after this that Mrs. Edwards was at last prevailed on to go away from home for a rest. Miss Carrington raised the necessary funds from a society in Boston. The family was provided for by the local social agency which arranged through the parish priest to have the children looked after by a capable woman who lived near by. Mrs. Edwards spent five weeks at the convalescent home; she made great

gains in every way, for she took to herself the object lessons she learned there in systematic work, regular hours for meals and sleep, exercise and fresh air, and balanced diet. She was a little inclined to fret about the family, but after Miss Carrington arranged a daily letter from home as well as frequent ones from herself, to all of which Mrs. Edwards was asked to send only occasional replies, she settled down more contentedly. At the end of her five weeks in the convalescent home, she reported at the Cardiac Clinic, where the physicians were much pleased with her improvement.

It was perhaps inevitable, although regrettable, that Mrs. Edwards was not able to hold all of her gains after she went home. The wear and tear of family life gradually brought about a recurrence of some of the physical symptoms, but she was decidedly better than before. Miss Carrington lost no opportunity of helping her to apply better system in doing her housework; she kept before her a sensible plan of living and she tried to influence both Mr. Edwards and the children toward the same end. She was alone in this endeavor, as the local social agency was no longer working in the town; her work, therefore, had to be extended to cover more than the medical aspects of the social problem. Thus, she assisted the family in gifts of necessary clothing when unemployment came to Mr. Edwards, as well as in helping in a search for work. She advised about Jennie's education, which was being directed toward a college course by her teachers, who were in ignorance of the social factors which made such a plan inadvisable — indeed impossible. Miss Carrington took up this question with the principal of the high school, who was of the opinion that Jennie's mental endowment did not warrant one in expecting her to be able to enter college, so her school work was directed toward more immediately useful ends. Later on, when she decided to leave high school, this decision was approved by Miss Carrington because she was sure that Jennie was not really benefiting by further attendance at school. She was helped to find suitable work.

The above social treatment had to be carried on mostly through letters and the occasional interviews with the family at the hospital, since only one visit could be made to the home because of its distance from Boston. The various patients in the family reported faithfully at the clinics and made steady and consistent gains. At the present time they come once a year for the routine examination considered desirable for such cases. Mary has grown into a very dependable girl, who is her mother's right hand at home, now that Jennie is working. This relieves a good deal of the pressure on Mrs. Edwards. The financial situation is much improved by the addition of Jennie's wages; in short, the family, which was once a source of anxiety to Miss Carrington, has become one of which she thinks with pleasure and satisfaction.

COMMENT

This is an illustration of what must frequently be done by a medical-social worker when there is no local social case work agency available. In this instance the charitable agency in the home town was very willing to do everything it could, but there was no case worker in the agency, so that the greater part of the social treatment had to be carried out, if at all, by the hospital social worker, on whom fell the responsibility for the medical aspects and also the guarding against destruction of the family's independence and self-respect by judicious giving of material aid.

We see here why medical needs cannot always be met by a home which physically offers a good environment, but socially does not do so. The recurrence of the original patient's chorea was due in the physicians' opinion to too much excitement, work and school after she returned home. This might have occurred, anyway, but it is not probable, since her second convalescence in a suitable institution was entirely successful.

The very satisfactory outcome of this case may be attributed, of course, to several factors. The less obvious one, although still important, is the native quality of this couple and

their children; they were intelligent, with no serious character defects; they accepted guidance and advice and they had a sound family spirit, all of which offset the unfavorable financial situation.

As in many other cases involving school children, there is evident here an enthusiasm for higher education on the part of teachers which is capable of stimulating unwarranted ambitions. This episode emphasizes the great danger of influencing anyone's life without substantial knowledge of the facts.

E. W.

In this case the teeth and tonsils are blithely, but I believe wisely, ordered out. Especially important and wise is attention to the tonsils in cases of suspected or incipient 'rheumatic' heart disease and in many cases of 'neuritis' and other unexplained pains appearing 'out of a clear sky.'

But in medical work as a whole, the removal of teeth and tonsils is, I think, being terribly overdone. To produce this disaster two main forces contribute, (a) the ambition of eager operators and (b) the patient's satisfaction that '*a cause*' of his troubles should be located and extirpated. Most real causes are not single, do not reside in a single spot and cannot be extirpated. Causes are multiple, widespread, interwoven, and rarely to be picked out and thrown away like a maggot. The idea of a seizing and pulling out '*the* cause' of any evil, physical or moral, is, I fancy, a relic of the habits of thought under which devils and evil spirits were recognized and exorcised by our forefathers. It is exhilarating and satisfactory to throw one's inkstand at the devil and obliterate him. The same naïve and athletic impulse animates many surgeons and those who submit to them. It seems practical, prompt and virile. But its results are often disappointing.

R. C. C.

CASE 2

DENNIS MCDOUGAL Age 14 *Single*

Admitted March 15, 1920; discharged April 4, 1920.

MEDICAL SOCIAL PROBLEM

Heart disease in a fatherless boy; very meagre income.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Rheumatic heart disease with endocarditis, aortic regurgitation; question of chronic nephritis.

b. *Prognosis:*
Good for recovery from present attack. Cardiac lesion is an old one and heart is permanently damaged.

c. *Treatment:*
Bed care at the M.G.H. until present attack has subsided. After discharge patient is not to return to school this term, but may expect to resume normal activities in the fall.

d. *Additional medical history secured by social worker:*
Prolonged exposure to pulmonary tuberculosis. Patient has been under supervision by City Tuberculosis Clinic as a pretubercular child. He was a 'blue baby' and did not walk until he was four years old.

Social
(Family and patient)

a. *Analysis:*
Father was born in Ireland; mother born in Massachusetts of Irish stock; Roman Catholics. Six sons born in Boston. Poverty and family dissension due to father's intemperance and mother's temperament. Father and four sons are dead. Father died of pneumonia following a spree. One brother died of rheumatic heart disease; causes of death of other three are not known. Mother has had sanatorium treatment for second stage pulmonary tuberculosis. Remaining brother is healthy. Mother's wages are $11 a week; rent $2.50 a week. Until recently income was $9 from Mothers' Aid. Legal settlement in Boston. Mother educated in public schools but did not graduate from grammar school. Brother is in eighth grade of grammar school. Mother employed as wrapper in large department store; hours 1 to 10 P.M. Father said by social workers, knowing family, to have been a fine type of man with only one failing — drink.

Medical (Patient only)	*Social* (Family and patient)
	Considered superior to mother in every way with this exception. He was a railroad fireman and had an excellent work record. She is devoted to children but is unwise; has a difficult disposition; lacking in control of hot temper; is not a good disciplinarian. Poor homemaker but careful about appearances; anxious to be self-supporting; accepts advice; holds affection of children. Patient has never known anything but a poor home and the deprivations of poverty; he has been fatherless since age of six. Has had to seek amusements in crowded city district without supervision of mother, but has had access to excellent Settlement House. Was a delicate young child and has never been rugged. Is now in last year of grammar school; has an active mind and is fond of reading fiction and adventure. He is an attractive boy with good disposition; very fond of mother.
	b. *Treatment:* Supervision for five months. Medical instructions carried out. Coördination of social agencies interested in family. Home visits; medical situation interpreted to mother and social agencies; further medical care secured. One year later, medical examination of patient arranged and reported on at request of another agency.
	c. *Sources of information:* Social agencies, including Family Welfare, Children's, Public Relief, Public Health and Community.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Not available because of inability to pay for medical services, but city physician may be called.
b. *Hospitals:* Hospital care is not needed.
c. *Nursing homes:* Impossible because of finances.
d. *Convalescent homes:* Not suitable.
e. *District nurse:* Not called in, as mother and brother can meet patient's needs.

Social

a. *Family and patient:* Good family spirit. Excellent attitude on part of patient. Cheerful home atmosphere in spite of dingy, untidy quarters on third floor of old residence in congested city district.
b. *Relatives:* Are not in a position to help in any way.
c. *Benevolent individuals:* interested indirectly through social agencies.
d. *Private agencies and institutions:* Settlement House and Children's Agencies. Employers' Welfare Department.
e. *Public agencies and institutions:* Overseers of Public Welfare and Mothers' Aid Department.

NARRATIVE

One morning, when making my ward rounds as usual, I noticed an attractive woman sitting at the bedside of a young boy, obviously her son. A glance at his chart showed me that he was not on the Danger List; evidently he was not having a visitor out of hours for this reason. A few minutes' chat brought out the fact that, as Mrs. McDougal worked during the hospital visiting hour, she had special permission to see her boy at eleven instead of at one. Dennis had come into the ward only the day before, so he and his mother had much to talk about that morning, and as he was far from feeling uncomfortably ill, the conversation was a merry one. Who can see more clearly the humorous side of novel experiences than a wide-awake lad?

During the next ten days I saw Dennis every day, and gradually learned enough of his history to make me feel that he would need supervision at home for some time if he were to get the utmost benefit from his hospital treatment. The doctor agreed with me, as he foresaw a prolonged period of re-

stricted activity. Mrs. McDougal was glad to talk over with me the care Dennis ought to have and welcomed suggestions. She was not especially communicative about her past and gave only a general summary; but the outline of the family history given by Mrs. McDougal, when filled in with the details supplied by various social agencies, gave me a fairly clear idea of what I had to work with and against.

Mr. McDougal had had 'a strong weakness' for whiskey, a taste shared by his mother, who had lived with the family off and on. His many positive virtues had not atoned for his failing, in Mrs. McDougal's eyes, and as for his mother she could not express her scorn! Mrs. McDougal's own mother, twice widowed, had brought up a number of children with some slight assistance from a social agency and her only acquaintance with the evils of drink came from associating with the McDougals. On one occasion Mr. McDougal had assaulted his mother-in-law while he was intoxicated; as a result medical attention was required. The respective merits of their mothers had been a fruitful theme of spirited discussion for Mr. and Mrs. McDougal. Things had finally reached such a pass that the home had to be broken up. Mrs. McDougal was sent to a convalescent home and the children placed out with the help of a children's agency. When rested, Mrs. McDougal went to work to support the family. Six months later she took back her husband, as he had not been drinking for some time and it seemed safe to reunite the family at this point. The social workers and the parish priest, although they thought Mrs. McDougal none too coöperative and rather held her to blame for her husband's delinquencies, decided to send Mr. McDougal away for treatment. Accordingly he went for a few weeks to a State Hospital for inebriates; however, treatment was of no avail and he died soon after he returned home. The cause of his death was pneumonia contracted while on a spree. During these unhappy years four of the children had succumbed; the fourth one died of heart disease only a few days before Mr. McDougal's death.

The next outstanding event in the family history was the discovery that Mrs. McDougal, who had been ailing for a long time, was in the second stage of pulmonary tuberculosis. Again the children were placed out and Mrs. McDougal went to a sanatorium for eight months. After her discharge she was kept under supervision by the Tuberculosis Dispensary of the city; at frequent intervals a nurse visited the family which was once more established in the same neighborhood. Both of the boys were examined at the Dispensary from time to time, although under protest. After Dennis was haled into Juvenile Court at the age of eleven for breaking windows, the Probation Officer saw to it that he reported at the clinic at the required intervals. Soon after leaving the sanatorium, Mrs. McDougal was granted Mothers' Aid, and on this allowance of nine dollars a week from the State she supported herself and the two boys until Dennis became fourteen when, under the law, the aid had to be discontinued.

Her good friends at the Settlement House, who had stood by her through all the vicissitudes of the past, now helped her to get work which brought in two dollars a week more than her allowance had given her. True, she had to work every evening until ten, but her boys were always at the Settlement House, so she did not worry about them. Her mornings she gave to her own housework. As soon as Dennis should graduate from the grammar school, he could get a job too; the future began to look bright.

Then Dennis fell ill. The Settlement House secured from a supporter of the House the use of a Free Bed at the Massachusetts General Hospital and Dennis entered the ward. Now there appeared upon the scene a new kind of social worker of a brand heretofore unsampled by the McDougals. Could she possibly be as helpful, not to say as likable, as their devoted friends at the Settlement, or would she turn out to be like the social workers at the other agencies who were hard to get on with? Mrs. McDougal was quite frank on this point, although the various social records bore testimony that there were those

who felt that Mrs. McDougal was not the most amiable woman in Boston.

When Dennis was ready for discharge, the doctors told me that he needed no medicine; his activities, however, should be restricted during the next six months. He was not to return to school during the present term and such sports as swimming, baseball, etc., must be omitted. Dennis, who felt perfectly well, was much disappointed, but behaved well. I went over the entire situation most carefully with Mrs. McDougal, who thoroughly understood what might be the outcome if Dennis disregarded the doctors' advice.

A few days after Dennis went home, I called at the Settlement House and had a long talk with one of the residents. He spoke very highly of the family whom he had known for years. He assured me that everything that was possible would be done in the present situation and I need feel responsible only for the medical aspects.

Dennis reported at the clinic in due season and was found to be in good condition. The physician thought that a little light work would not be harmful, provided it did not involve stair-climbing or walking. Mrs. McDougal was delighted, and told me that she would see the Overseer of Public Welfare that afternoon, as the latter was considering giving her a small allowance because of Dennis's illness; now she would ask instead for help in finding the right kind of job for him. She emphasized her liking for this Overseer, who was almost as nice as her Settlement friends. Amongst them all she never lacked for good advice.

Ten days later, Mrs. McDougal telephoned me in great distress. Dennis was seriously ill and she asked that he be admitted at once to the Hospital. By the direction of the Hospital Superintendent I asked the City Physician to visit Dennis. Upon his report that the illness was serious, our ambulance was sent for the boy. He was found to be in exceedingly poor condition, which was very puzzling in view of his recent visit to the clinic. He said he had obeyed all orders

absolutely and had not done any work. Mrs. McDougal told the same story. A chance remark of his, however, led to the discovery that Dennis had been so exhilarated by his examination at the clinic that he had decided to go swimming with some of his friends. Several such excursions in the afternoon, after his mother had gone to work, cost Dennis dearly. Weeks of care in the Hospital served only to get him to a point where it was thought nothing further could be done for him. The doctors told his mother frankly that the prognosis was very bad, as not only was his heart in exceedingly poor condition, but there was also some nephritis. They recommended that the boy be allowed to do about as he pleased, the main thing being to keep him as comfortable and happy as possible. A low protein diet was advised purely from a palliative point of view. When he was sent home, about six weeks after he came in, the unquenchable optimism of his nature was in pathetic contrast to what we all knew about his probable future.

Once more I talked with several residents at the Settlement, telling them of the change in Dennis's prognosis. It was the consensus of opinion at the Settlement that Mrs. McDougal and Dennis were much alike and very difficult to influence, but suitable plans to provide recreation and encouragement as well as material comforts would surely be made. When I visited the home, I found Dennis contentedly sitting up in bed reading a book sent over from the Settlement. He was surrounded by offerings from his friends — fruit, flowers and magazines. But the room was untidy and dusty, and the bed, though comfortable, was much in need of fresh linen.

I was not long in doubt as to how his mother was interpreting the doctor's advice to keep him happy. The boy was simply revelling in freedom to follow his own fancy, restrained only by his lack of inclination for very strenuous exercise. A neighbor, who had a delivery wagon, was giving Dennis many drives. He was keeping to his diet only because he liked it.

Presently his mother came in laden with parcels from which emerged various good things to eat including a lemon meringue

pie. This was saved from instant demolition only by the clock, which showed that the morning was still too young to allow of even an emancipated boy's devouring pie. Mrs. McDougal beamed with delight at evidence of so normal a juvenile appetite.

When I left, Mrs. McDougal went downstairs with me. She dwelt on her firm intention to let Dennis do as he chose regardless of his heart. Restraint made him miserable, so there was to be none. She was then having two weeks' vacation which she was spending at home and they were having such a good time that she so far had had no chance to clean up the place. She therefore apologized for the general untidiness of the rooms, but surely no one could spend a minute of a vacation in anything so prosaic as sweeping and dusting and putting away clothes. I was quite refreshed and in a sort of holiday mood myself by the time I left her.

There is little more to tell. I talked with the nurse in the Welfare Department of the shop where Mrs. McDougal was employed, and she said she would drop in from time to time to see Dennis, as well as do anything else she could. Then I withdrew, as the Settlement workers undertook full social responsibility. About a year later, a children's agency asked me to have Dennis examined, as they were sending him to the country for the summer at the request of the Settlement House. He was found to be in excellent condition, his heart being compensated and his kidneys all right. Mrs. McDougal told me that he had been allowed to do exactly as he pleased until he was able to hold an easy job as errand boy. He had worked at this for a few months, then had had a 'bad turn,' but three weeks in bed had restored him to good health. Since this episode he had been feeling very well. The doctor gave Dennis permission to do light work, such as chores which a boy would do on a farm; but he forbade baseball and similar strenuous games. Dennis got on very well, and in January, 1922, he was working on a job which kept him outdoors all day cleaning windows.

COMMENT

Perhaps it seems that the lesson to be drawn from this case is to let your patient do what he wants to. However, what it demonstrates is what everyone interested in medicine knows: that there is nothing more difficult than to prognosticate. Furthermore, it shows that social conditions influence medical ones. There is no doubt that this boy, left to follow his own fancy, profited because there was no friction; he wasted no energy in scenes with his mother; he was happy and he did not overdo because he was intelligent enough to profit by his experience with the swimming; moreover, his energy was sufficiently reduced by his illness and possibly by his diet so that he did not really care to do the things which were injurious to him. The case also illustrates the very great influence of a Settlement House where all members of a family are known and where such tendencies as may be inherited from the parents can be recognized in the children and skilfully handled. The contact of the hospital social worker was confined to the period of medical crisis because her colleagues stood ready to go on with the necessary social case work. An ideal arrangement in many cases, in a community which affords good social agencies of the various types.

E. W.

'Light work': one of the young medical-social worker's commonest delusions is that it should not be difficult to find such. As a rule it is impossible. In this case, however, it was play rather than work, which proved the patient's undoing, and this is often the case in children. In the end the job which he is able to hold was certainly *not* a very light one.

Yet in spite of the above assertions it must be confessed that in Case 6 and Case 8 of this cardiac group 'light work' *was* apparently found. For the tuberculous it is often sought in vain, and when found is often refused at the start or soon given up because its 'lightness' usually means lower wages than those earned before the illness.

Alcoholism, though it is much less frequently a problem among the poor than it was before prohibition, still presents one of the most serious and baffling of the social worker's tasks. Loss of income, family brawls, cruelty to wife and children, breaking up of homes, illness and death of the alcoholic, as in Case 2, are problems still facing us and we are still very powerless before many of them, though we see many alcoholics straighten out without our help.

R. C. C.

CASE 3

MORRIS SIMOFSKI Age 15 *Single*

Admitted to ward December 14, 1921; discharged from ward January 5, 1922.

MEDICAL SOCIAL PROBLEM

Rheumatic heart disease; unfavorable home conditions; heredity involving mental disease; poverty; lack of parental discipline.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Rheumatic heart disease with active endocarditis; mitral stenosis; aortic regurgitation. Diagnosis of chorea was made four years ago by a good clinic, but beyond a tonsillectomy no treatment was apparently given, for patient failed to report and was lost sight of.

b. *Prognosis:*
Is hopeful if patient is given complete rest for from four to six months with gradual resumption of normal activities.

c. *Treatment:*
Salicylatis for at least six weeks. Bed care for one month after discharge from ward; then for another month gradual resumption of normal activities; then rest with especial attention to hygiene for next four months.

d. *Additional medical history secured by social worker:*
Verification of mental disease in patient's heredity.

Social
(Family and patient)

a. *Analysis:*
Parents, brother and patient are Russian Jews who came to the United States about 1910; have not had an easy time here. Mother died in New York several years after arrival; was a patient in hospital for insane; diagnosis, manic-depressive insanity. For past six years father, patient and brother have lived in Boston; father is a plasterer earning when at work about $40 a week. Father's health was not good; brother is all right. Father is very poorly educated; brother is in sixth grade of public school; patient in second year of high school. Brother and patient are quite well-behaved, studious and ambitious; father is restless, dissatisfied, hot-tempered; he gambles and drinks. He is very fond of sons, whose future is matter of deep concern to him.

b. *Treatment:*
1. *Plan:* Place patient in foster-home, supervise him in cardiac clinic, advise him about future work. Influence

Medical
(Patient only)

Social
(Family and patient)

father to make better arrangements at home; connect brother with a social agency which will supervise.

2. *Results:* Patient placed out by social agency with excellent results, medical and social. Father persuaded to change mode of living; suitable supervision secured for brother. Patient advised, guided vocationally; kept under supervision of clinic.

c. *Sources of information:*
Social agencies.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Is not needed; since patient is to be under supervision of clinic. L.M.D. does not care to continue with case.
b. *Hospitals:* Hospital care not necessary after discharge from M.G.H.
c. *Nursing homes:* Are not suitable and are too expensive.
d. *Convalescent homes:* Are not suitable.
e. *District nurse:* Is not needed.

Social

a. *Family and patient:* Home is a tenement of three rooms and bathroom up one flight in dark house in the rear of a larger building. Father unable to cope with situation; brother is too young to be a factor.
b. *Relatives:* Three uncles are much interested, but are unable to give financial aid.
c. *Benevolent individual:* None is interested.
d. *Private agencies and institutions:* Are available for placing out patient and for supervision of brother.
e. *Public agencies and institutions:* Are not needed.

NARRATIVE

The day after Morris Simofski was admitted to the ward, Miss Sargent, of the House Social Service, noticing a new patient as she made her daily round, began her acquaintance with him. Following the course of his illness carefully and foreseeing that the boy would need prolonged care after his

discharge from the Hospital, she turned her attention to his home to see whether it offered proper conditions for convalescence. Talking with Morris himself, with his father and his younger brother David, and verifying the facts she gathered from them, she decided that it offered no chance at all. The rooms they occupied were dark and damp; the mother had died several years earlier and there was no woman in the family; the meals consisted of canned food. Miss Sargent, therefore, consulted the physicians in charge as to the wisdom of placing Morris in a suitable foster-home. They approved of the plan and Mr. Simofski gave his consent.

Applying to a children's social agency for assistance, Miss Sargent laid the facts before them. The physicians believed, she told them, that if Morris could receive proper care at this time, his health might be reëstablished; otherwise, the heart condition would probably advance to the point where the boy would be permanently crippled. He was a good boy and bright, and showed promise of further improvement, mental and moral, if he were given half a chance. Accordingly, she asked the agency to care for him for a period of from four to six months.

Then she turned her attention to David, who seemed to need help almost as much as his brother. For a thirteen-year-old boy, thrown on his own resources, David seemed to be getting on fairly well; but cold luncheons at noon with inadequate breakfasts and suppers were physical obstacles, and the neighborhood was one known as presenting many dangers to children without good home influences. Mr. Simofski apparently gave little supervision to his boys. Moreover, he drank and gambled, as Miss Sargent learned from the social service department of a hospital where he had been a patient. This report was corroborated by a Settlement house which knew the family slightly.

It was through this Settlement, that the solution of David's problem came. Miss Sargent went over the whole situation with the workers there, and handed David over to their care.

They undertook to give the boy his meals and to keep him occupied out of school hours. Mr. Simofski accepted the plan cordially.

As she came to know Morris better, the favorable impression he had made upon Miss Sargent was strengthened. Although the boy was not exceptionally bright, he was sufficiently so to indicate that he would make a good clerk in an office where there would be no great physical strain. In view of his mother's mental disease, the facts concerning which Miss Sargent had obtained from the hospital where Mrs. Simofski had been treated, she kept constantly in mind the wisdom of attention to mental hygiene, for Morris was distinctly afraid of developing his mother's ailment.

Upon his discharge, Morris was sent to a good foster-home in a small town near Boston. The foster-mother, a woman of considerable experience in the care of the sick, had, since her marriage, taken two or three children at a time to care for through the agency which sent Morris to her. Results had been most favorable in former cases and proved to be the same in Morris's. He gained steadily, faithfully following the treatment outlined by Miss Sargent in accordance with the doctor's orders.

Morris was brought into the Cardiac Clinic from the foster-home several times, as requested by the physicians to whom Miss Sargent reported the accounts she received from the agency in charge of the boy. At the end of six months, he was allowed to return home, the agency, however, continuing its supervision. Meantime, the home had become another place, a relative having joined the family who did much to fill the mother's place. From time to time the social worker in charge of the boy gave Miss Sargent excellent reports of Morris, and together they consulted upon his further education. In view of his mental background, the agency had had Morris examined by a psychiatrist specializing in the treatment of children. He advised routine office work as best suited to the boy's physical and mental capacities. Morris's course at high school

was accordingly changed; but he did not remain in school long after that. He became restless, anxious to be working and earning money; and as his father's health was increasingly poor, it seemed well to advise the boy to leave school for a clerical position in an office.

Under treatment at a good dispensary, Mr. Simofski gradually regained his health. Abandoning his trade as being too laborious, he opened a small shop which offered employment to Morris as well as to himself. Mr. Simofski, who had had experience with similar work in Russia, was backed financially by a friend. Morris was delighted with the arrangement; he was enabled to restrict his work as advised by the clinic, and yet had the chance to get ahead that he would never have had in the office of another.

When last heard from, two years after Morris was in the Hospital, the family was favorably situated in all respects. They had moved into a better neighborhood and seemed to be on the upgrade generally. Morris reports faithfully to the clinic, as directed by the physician, about once a year. While his heart has definite damage of a permanent nature, it seems probable that he will be able to live within his limitations, which he thoroughly understands. And if at any time any acute disease should arise, so strong is the hold Miss Sargent has upon him that she would be notified at once and would be enabled to take steps to secure medical care for him.

COMMENT

Morris illustrates a type of medical-social treatment which has worked out in Boston with special success. It implies, of course, close coöperation between the medical-social worker and the children's agency; and for a certain group of cardiac diseases in children, it offers advantages over institutional treatment. The choice between the two plans is based mainly on the medical factors. The social situation, however, is considered by the physician in such cases, where the home conditions include moral weakness in parents and consequent lack of

helpful influences. Much may be gained by placing a child in a good American home where he learns many things which he carries back to his family which would hardly reach them in any other way.

The homes are carefully chosen and are closely supervised by the agency. Many of the foster-parents are capable of making genuine contributions to the general development of the children in their homes as well as of giving them the sort of physical care demanded by their medical condition. The homes are generally located in the suburban area or even farther out in the country, but are always near enough to the city for the children to visit the hospital clinics as ordered by the doctors.

E. W.

The worker's mind has been influenced by the most dangerous part of 'mental hygiene' propaganda. Although much of the work of the national and local societies for mental hygiene is of great value, they are alienating the sympathies of their more thoughtful supporters by leading the public to believe that insanity (aside from that due to alcohol and syphilis) is preventable. This the public is most anxious to believe and ready to forward by contributions and by personal efforts with children at home and in school. Unfortunately, there is strong reason to believe that disappointment and disillusion are on the way. Few neurologists or alienists of wide experience will maintain that insanity of any type recognized to-day can be prevented by mental hygiene. The few who do believe this are mostly psychologists without wide clinical experience or Freudians of the extreme type. The alcoholic and the syphilitic psychoses can, of course, be banished whenever the community determines to rise to a higher moral plane and so to banish syphilis and alcoholism. But that dementia præcox, and manic-depressive insanity, paranoia, senile dementia, arterio-sclerotic insanity can be prevented by any means known to science to-day is not believed by the great majority of competent observers. No proof of it is at hand.

It is most unfortunate, therefore, that contributions should be solicited and expectations aroused on the basis of statements quite lacking in scientific foundation. It undermines the success of other truly scientific propaganda and is quite unworthy of officers of the society.

R. C. C.

CASE 4

MARIE FRANCK Age 15 *Single*

Admitted to ward on February 2, 1920. Discharged February 20, 1920.

MEDICAL SOCIAL PROBLEM

Acute rheumatic fever, rheumatic heart disease, prolonged bed care away from home, interpretation to parents of implications of diagnosis.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Acute rheumatic fever; old rheumatic heart disease with mitral stenosis and regurgitation; acute endocarditis; chronic suppurative otitis media. Long history of 'colds,' sore throats and discharge in ear following on measles at age of ten.

b. *Prognosis:*
Good with proper treatment.

c. *Treatment:*
Complete rest in bed for several months.

c. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Father was born in Belgium, his native tongue being French; mother was a native of France; both were Protestants. Father came to the United States as a young man, leaving mother and patient at home. Mother died when patient was very young, so she was brought up by father's parents in Belgium. Father remarried in this country, stepmother being a native of Pennsylvania. They have no children. They have both worked aiming to earn enough to buy a farm. Owing chiefly to World War, father left patient in Belgium until shortly before admission to M.G.H. Income is about $18 a week at present, as father is out of work; he earns about $30 a week when working. Rent is $22 a month for four rooms on the second floor. No legal settlement in Massachusetts. Health of father is very good, but stepmother has many sore throats with occasional rheumatism. Father and stepmother have little academic education, but have a good deal

Medical
(Patient only)

Social
(Family and patient)

of knowledge of business, a wide observation of life, and the stepmother, especially, has excellent judgment and common sense. Father is a restaurant waiter; stepmother is a cook. Both enjoy their work and are proficient. Father is hard-working, sober, with domestic habits; very fond of family. Stepmother is lively, energetic, cheerful and courageous, affectionate and generous, ambitious to obtain things worth while, resourceful, receptive of new information and ideals and discriminating. Absolutely devoted to patient. Patient led a very quiet life in Belgium until outbreak of World War, then she saw much of the horror and disaster. Lived through air raids which have profoundly influenced her. Sorry to leave grandparents when she came to the United States, but has adjusted herself readily to life in America. Has had comparatively little schooling, but is in some ways more advanced than others of her age, although in other respects behind. Work in the household she learned abroad; here she became first an unskilled worker in a factory and later did housework with a farmer's wife, not as a servant, but as an assistant to her mistress. Liked this work, but not that in the factory. Is alert and intelligent in manner, affectionate, especially to stepmother, but shy and immature in many ways, gentle and apt to keep silence in the presence of adults. Has evidently been de-

Medical (Patient only)	*Social* (Family and patient)
	veloped on lines typical of French girlhood which has kept latent her initiative and poise; appears much more childish than average American girls of fifteen; pretty and very likable.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Cannot be afforded for regular treatment.	a. *Family and patient:* Devotion and intelligence of parents will insure medical orders being carried out. Patient's character gives similar guarantee. Home is not especially desirable in some ways but can be made more so.
b. *Hospitals:* Patient is suitable for chronic hospital giving prolonged bed care.	b. *Relatives:* No relatives in this country.
c. *Nursing homes:* Nursing home instead of hospital would be acceptable, but is too expensive.	c. *Benevolent individual:* None.
d. *Convalescent homes:* Cannot give requisite care.	d. } *Public and private agencies and*
e. *District nurse:* Is not needed.	e. } *institutions:* Are both available.

NARRATIVE

Three days after Marie was admitted to the ward I decided that I might as well begin on the preliminary investigation, as the child would surely need prolonged care; should her own home prove unsuitable, probably care in Mercy Hospital or in a foster-home supplied by a children's agency would be necessary. Marie was an attractive little girl with long brown curls and big dark eyes. Small for her fifteen years, she was shy and retiring, childlike in manner and appearance. There was not the slightest hint of anything abnormal about her, yet one received an impression of difference from the usual girl of her age. She spoke very little English, but chattered freely in French to those who had won her confidence. As I learned her history, I could see why she did not resemble other young girls; there was really every reason why she should not.

Owing to her mother's death when she was very young and to her father's absence in America, her early childhood

had been spent with her paternal grandparents in a small town near a large city in Belgium. Marie was happy there and loved her relatives, but had always longed to join her father in the United States, especially after he married again when she was seven years old. However, for one reason or another, she remained where she was until the World War made it impossible for her to get away. She had many terrible experiences during the war, frequently having to take refuge in a cellar during air raids. Cousins in the army related their adventures to her. Thus she was inured to things of which our fortunate American children have had no knowledge, but with it all she was not embittered nor intimidated. One might almost say that she was what she was because of her long residence with an old couple who doubtless had ideals of girlhood of at least fifty years ago. Probably such maxims as 'Children should be seen and not heard,' rather than the war, accounted for her reluctance to occupy the centre of the stage.

I talked with the parents, interpreting Marie's diagnosis into homely terms which they could readily understand. When they realized what type of care she needed, they agreed with me that she could not have it at home. The family had four rooms on the second floor of an old residence in what had once been a very good street and was still a quiet and clean one. There was good light and ventilation and they were lucky enough to have a bathroom. The furnishings were meagre; the heat was derived from the kitchen range. There was, however, no one at home during the day, since Mrs. Franck was working and Mr. Franck seeking a job. Later on, after Marie was able to be up and when the most extreme cold weather was over, we all thought that she could safely return home. For the present, a hospital seemed advisable.

Admission to Mercy Hospital was arranged, the Superintendent deciding, in view of the circumstances, to take Marie as a free patient. When the time came to go with me in the ambulance, Marie shed quantities of tears at leaving the ward where she had made many friends, but once she was estab-

lished in her bed at Mercy Hospital and saw herself surrounded by a most pleasing assortment of young girls, her face began to beam. She was very happy there and made extraordinary progress, and as an educational method her stay in that ward could hardly have been improved on, for Marie learned English with great rapidity.

I saw Marie whenever I was in the vicinity. At the end of two months she was up eight hours a day and in very good condition. It was therefore considered safe for her to go home; although somewhat restricted activities still seemed advisable. A tonsillectomy was recommended within the next month or two.

Marie had not been home a week before the rheumatic pains in her legs returned. After consultation with the physician, I put her to bed for a few days until she could report at our Cardiac Clinic. As Mr. Franck had found work a few days before, Mrs. Franck remained at home with Marie. When the latter was seen at the clinic, the doctor ordered her to stay in bed another week during which time morning and evening temperatures were to be taken and reported to me. Mrs. Franck grasped readily my instructions on taking and recording the temperature.

On a home visit I found things going on very well; Marie's temperature had not been above 98.4°. She had no pain or other untoward symptom, but was in alarm lest she be in for another siege. A careful explanation of her condition reassured her. She was patient and obedient, passing her time with French and English books, not fretting when her mother's necessary absences left her alone. On the whole, her surroundings were pleasant, for they were clean, orderly and sunny.

On her next visit to the clinic, since her temperature had not gone over 99° the physicians thought an appointment for tonsillectomy advisable. While we were arranging this, I noticed that Mrs. Franck had a 'sore throat,' and after much persuasion she consented to be examined. In view of her history of tonsillitis for years, she was advised by the doctors to go to

bed for a few days and then come in for an appointment for tonsillectomy. Still more persuasion was needed before Mrs. Franck would agree to this, but finally she yielded.

In due season both Marie and Mrs. Franck had their tonsils out; they got on well, probably because they followed instructions to the letter. Within a month of Marie's operation, she began to show marked general improvement; there were no more rheumatic pains, her vitality was noticeably greater and she was attending some clubs at a near-by Settlement House which I recommended to her. I saw her quite frequently both at home and at my office and was delighted with her condition. Five months after Marie first came into the ward, the physician in the clinic reported to me that her heart was normal, and that while he would like to see her again in four months, there was no absolute need of this.

From then on matters went very well with the Francks. Even Marie was able to work at a job in a factory which did not greatly tax her strength. They saved money and at last bought a farm in western Massachusetts, where they have now established themselves and are beginning to cater to travellers. Considering the combined skill of the family and their wise choice of a location there seems to be an excellent chance of their building up a profitable business. The home has been most comfortably furnished, with especial attention given to making it the attractive place in which a young girl likes to entertain her friends. On one occasion Marie required medical care for a recurrence of the old ear trouble, and as it seemed inadvisable for her to come to Boston, I recommended a local practitioner who treated her successfully. Occasionally, if she does not seem in the best of health, she comes to Boston to our clinic, but the physicians continue to give reports on her heart which have led to her classification as a case with good prognosis. She has grown into a young woman of very good physical development, thoroughly at home in America, and very happy here — as she well might be — since the family is a singularly united and contented one.

COMMENT

It is cases like this one, which is in no sense unique, which give rise to the hope that by supplementing the best medical treatment with careful social work, rheumatic heart disease may finally be practically eliminated. It means long-continued intensive work and calls for the use of all possible therapeutic assets, but it is worth every bit of time, energy and skill which the social worker can bring to bear and all the aid which she can mobilize in support of the medical treatment.

E. W.

CASE 5

ESTHER MCADAM Age 26 *Single*

Admitted January 30, 1921; discharged March 14, 1921.

MEDICAL SOCIAL PROBLEM

Rheumatic heart disease; inadequate family income; probable dependency of patient; alarm and discouragement.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*

Bronchial pneumonia; acute rheumatic fever; pericarditis with effusion. Patient had measles and pertussis in childhood; no other diseases. Present illness began with a sore throat; wrists, arms, shoulders and legs became painful and stiff.

b. *Prognosis:*

Poor, as cardiac condition is of long standing and damage is severe. Patient was on Danger List for about two weeks.

c. *Treatment:*

Patient will need weeks of hospital care with months of convalescent bed care after discharge from hospital. Orthopedic service advises keeping all involved joints active.

d. *Additional medical history secured by social worker:*

Patient had innumerable 'colds' and sore throats during childhood.

Social
(Family and patient)

a. *Analysis:*

Parents Roman Catholic, born in Ireland. Nine brothers and sisters born in United States. Poverty due to father's intemperance and inability to hold jobs. Family income of approximately $40 per week; rent $28 per month. Legal settlement. Much illness and under-nourishment. Parents are poorly educated; the children have attended public schools. Father is an unskilled laborer; mother has done washing and cleaning as well as own housekeeping. One brother is a mechanic; one a helper in a shoe factory; one sister is an office clerk; other children are in school. There has been much unemployment due to industrial conditions, not to personal fault, excepting in case of father. Father is a drunkard and shiftless. Mother is energetic, intelligent, has cheerful disposition; is a good homemaker; gives excellent care to children. Eight living brothers and sisters are all of good character and devoted to mother and one another. Patient is

Medical
(Patient only)

Social
(Family and patient)

American born. She had early experience of privation and unhappiness due to father's character. She had minor ills during childhood, but was healthy until present illness. Is a graduate of high school. Has had steady work as a stenographer in a factory office. Likes her work. Is unselfish, amiable, coöperative, intelligent, and has good moral standards. Devoted to her family.

b. *Treatment:*

1. *Plan:* Carry out medical instructions; advise and encourage family and patient.
2. *Results:* Home visits made; advice given on health, housekeeping; work; education. Further medical treatment secured and financed. Visits to clinics arranged and supervised. Medical situation interpreted; attitude of family toward patient influenced. Supervision given over two and a half years. Patient and family taught to overcome alarm and discouragement. Friendly relations established.

c. *Sources of information:*
Family; patient; friends; head nurse; other social agencies.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Financially unable to employ one over a long period of time.

b. *Hospitals:* Private are not available because of prognosis. Public almshouse not considered because home is preferable.

Social

a. *Family and patient:* Are united by strong bonds of affection and consideration for one another. Home is a fairly comfortable apartment on second floor of an old residence. Neighborhood is of mixed residential and commercial type.

Medical
(Patient only)

c. *Nursing homes:* Too expensive.
d. *Convalescent homes:* Patient too ill.
e. *District nurse:* Not needed, as mother can care for patient.

Social
(Family and patient)

b. *Relatives:* No relatives able to help.
c. *Benevolent individual:* Mrs. Henry Johnson, Beacon Street, Boston.
d. *Private agencies and institutions:* M.G.H.; Children's agencies; Convalescent Home; Mercy Hospital.
e. *Public agencies and institutions:* No public aid given.

NARRATIVE

A FEW days after Esther was admitted to the ward, Mrs. Johnson, a philanthropic lady, came to me and asked that convalescent care be arranged for Esther. Mrs. Johnson said that Esther was occupying her Free Bed. She had been interested in her for a long time. If financial aid was necessary during the period of convalescence, Mrs. Johnson would be glad to give it. As I already knew Esther in the friendly way in which I knew all patients in that ward, I told Mrs. Johnson at once that Esther was on the Danger List; if she lived, she would undoubtedly need prolonged after-care.

At an early opportunity I drew Esther's mother away from the bedside and told her that Mrs. Johnson had spoken to me about her daughter. The name of Mrs. Johnson proved all that was necessary to establish me in Mrs. McAdam's confidence. As Esther fought her way through, her mother came to me day by day for comfort and courage when it seemed that the fight would be lost. Gradually it became clear that Esther would live, but the doctors were still very discouraging about the future. Mrs. McAdam's soul quailed as she faced a long illness for her daughter. She had been through it before with her son George, who had died a few years before of 'valvular heart disease.' Was Esther to go the same way?

The prognosis was carefully considered, the question of prolonged bed care at Mercy Hospital was discussed, but the poor prognosis finally excluded Esther. The alternative was care at home. Mrs. Johnson approved of this and gladly undertook

to supplement the family resources so that Esther could have comforts and even luxuries.

So Esther went home to lie for eleven weary weeks in a comfortable bed in the dining-room. There were three windows, so she had sun all day. Beneath her windows were lilacs and she revelled in their perfume. There were trees near the house, so she heard the birds. Her brothers and sisters tried to help her bear the tedium. The librarian at the local library picked out books for her. I dropped in as often as I could, carrying advice from the doctor in the ward when necessary. (No drugs were used.)

Mrs. McAdam was one of those hard-working, self-sacrificing Irish women whose virtues are of a very high order and whose intelligence is so good that defective education cannot obscure them. She had a most attractive personality. Esther was a lovable girl, devoted to her mother, brothers and sisters. Unassuming, grateful for every least attention, intelligent and of very pleasing appearance, it was not hard to see why the prospect of losing her was terrible to her family. As for the family as a whole, they had such good native endowment that hardships due to the shiftlessness and intemperance of their father had not depressed them below the level where they could lead a happy and useful life. The family spirit was excellent.

Esther and Mrs. McAdam were very brave and obeyed every suggestion, but at times they were so discouraged that it was hard to devise means of cheering them. Long before they realized it, however, it became apparent to me that Esther was improving, that she was even reaching a stage the doctors had thought she couldn't attain. I began to hope that after all she was eligible for Mercy Hospital. Finally, after Esther had had about seven weeks of absolute rest in bed, I went to Mrs. Johnson and asked her if she would pay for Esther's board at Mercy Hospital if Esther were now considered eligible. I reminded her that only patients whose condition gives promise of return to nearly normal activities are

accepted for treatment at this hospital. Mrs. Johnson was delighted to hear that Esther's condition had improved so much. She readily agreed to pay Esther's board at Mercy Hospital for a month to begin with, and longer if it were needed. It was at this point that Mrs. Johnson told me the story of how she came to know the McAdams.

One stormy winter's evening about 1900 she happened to be passing through the hall of her home just as her doorbell rang. She paused to learn who was at her door and at the sight of a poorly dressed woman, soaking wet and cold, she invited her to the library. Gradually Mrs. Johnson drew out the story of the weak, shiftless husband who could not keep away from whiskey, four children all under six who were suffering from hunger and cold, a fruitless house-to-house search for work for herself. From that evening dated Mrs. Johnson's unremitting interest and aid which she gave to the McAdam family through the years. When illness attacked them they were sent to the M.G.H.; vacations were arranged with the help of suitable agencies; work was supplied. Through it all Mrs. Johnson's respect and admiration for Mrs. McAdam grew, for she met misfortune with a brave spirit and found happiness in her ten children who were a most appealing little group. She tried every possible means of inducing her husband to give up drink, but without success. Mrs. Johnson stood by with advice and encouragement and material aid, always mindful of the danger of impairing the family's independence and self-respect.

Mercy Hospital accepted Esther. As this hospital was endowed, Esther could be boarded for only five dollars a week. Now that her admission was certain, I told Esther and Mrs. McAdam of my plan. They were delighted and held themselves in readiness for the summons from Mercy Hospital. Three weeks later it came. With another member of the staff I drove to Esther's home. We wrapped her in soft warm clothing and carried her — she was only a slip of a girl — out to the car and so to the hospital.

Five weeks later Esther was sent home. Her condition had improved and the doctors gave a most encouraging prognosis. A tonsillectomy was recommended. Now I bent my efforts toward getting the patient to come to the Cardiac Clinic in the M.G.H., and a few weeks later — five months after Esther had been discharged from this hospital — she reported at the clinic. Her condition was found satisfactory, but an operation was considered too great a risk. Therefore, X-ray therapy was tried, and after four treatments the tonsils were rendered harmless, in the opinion of the physicians.[1]

During this entire winter Esther reported at the clinic. She did no work other than light tasks in the home. Slowly but surely she gained ground, and about fifteen months after her discharge from the M.G.H. ward, she returned to her job which her employers had held for her all this time. The factory was less than ten minutes' walk from home; the hours were easy, as the business was a small one, and the work was light. Her luncheon was carried to her at noon by a brother, so she always had something hot and appetizing. I continued supervision.

Meantime, one of Esther's brothers was brought into the clinic because of a persistent pain in his side; he was watched for several months because the doctors thought he had an inguinal hernia of traumatic origin. Jimmie was an enthusiastic baseball player and was much upset by the surgeon's orders to discontinue the game for a year or two. Owing to a history of rheumatic pains with fever, his heart was carefully examined, but no signs of cardiac involvement were found.

At about this time Esther came to me to say that she wanted to pay a bill of ten dollars dating from her original stay in the ward; she had been told by the Hospital to pay it when convenient. I knew what it meant to the family to spare this sum, and I also knew that there was no danger of pauperizing

[1] Just before going to press it has been found necessary to operate for removal of the tonsils. The patient is in good condition and has had no ill effects from the operation.

them, so I went to the Assistant Director of the Hospital and told him Esther's history. On hearing it, he cancelled the bill.

Esther continued to report at the Cardiac Clinic as directed, the intervals between visits being gradually increased until she came but once a year unless symptoms developed. Two and a half years after Esther was first seen in the ward at the M.G.H., the record was closed. Since that time I have occasionally seen the family, with whom all has been going well. Esther has continued at work with only occasional interruptions due to 'colds' which have not become 'sore throats.' She recognizes her limitations and finds her work and recreations within them. She may reasonably expect to live and work and enjoy her life for many years.

COMMENT

This case is an excellent example of the kind of social and financial aid which may safely and wisely be given by a private individual under certain conditions. If there is integrity of character and intelligence in the patient and his family, and on the part of the benefactor, sympathetic understanding of the problem together with wise handling of the situation, there is small danger of pauperization. The McAdam family show not the slightest indication of this, either from the aid received through the benefactor or from the free treatment given by the Hospital.

The M.G.H. expects payment from those financially able to pay, but is exceedingly generous in the case of patients whose resources are meagre. They are given every consideration in the payment of bills if they voluntarily contract them, and each patient is afforded an opportunity to ask for reduction of rates or for free treatment. The existing arrangements may be changed later on in those cases where it becomes apparent that the hospital charges assumed by the patient cannot be met without imperilling his health or that of his family. As a result of this policy, the patients have a real loyalty to the Hospital. Many touching as well as amusing instances

of this nature may be cited: for instance, the family which rose from dire poverty in the North End to affluence in Brookline, but saw no reason to go to private doctors instead of the Out-Patient Department. The Hospital had stood by them while they were poor and they were not the people to forget this and patronize someone else now that they were rich!

From the medical point of view, Case 5 is gratifying, since the patient, first supposed to have a poor prognosis, has been successfully returned to her place as a productive member of the community, which place she is still holding nearly four years after her admission to the Hospital.

E. W.

The possibility of shrivelling up and practically abolishing tonsils by means of X-ray treatment is still *sub judice* in the medical profession. The dangers of X-ray treatment in skilled hands are very slight, the suffering for the patient zero, the expense probably much less than operation entails. On the other hand, operation even in the most skilled hands has serious dangers, involves suffering, disability and expense, and is a great temptation to unnecessary and sometimes botched operations in the hands of unskilled and unprincipled doctors. We await further experience with the results of X-ray treatment of tonsils eagerly hoping that time will confirm its value.

The change in prognosis in this case is due to the great difficulty in telling how much the heart is damaged when pericarditis — i.e., inflammatory collection of fluid in the bag which encases the heart — is present. It often sounds to the physician in such cases as if the heart valves were extensively damaged when in fact they are sound. Then the fluid may be absorbed and the patient left practically well.

R. C. C.

CASE 6

EDITH JENKINS Age 46 *Single*

Admitted to ward January 20, 1920. Discharged from ward February 15, 1920.

MEDICAL SOCIAL PROBLEMS

Angina pectoris; traumatic amputation of leg in a woman estranged from relatives, wholly dependent on herself.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Angina pectoris; traumatic amputation of leg at age of fifteen.

b. *Prognosis:*
Is fair.

c. *Treatment:*
Patient should have several weeks in bed or longer, if she is not thoroughly rested by that time; working conditions must be readjusted to eliminate fatigue.

d. *Further medical history secured by social worker:*
Father of markedly unstable temperament; some indications that these qualities have been transmitted to patient.

Social
(Family and patient)

a. *Analysis:*
Family is of English ancestry; has lived in New England for generations. Protestants. Parents are dead. Brother's whereabouts are unknown. Parents were divorced, mother having custody of patient. As father's relatives sided with him, mother and patient were completely alienated from them. Mother had no relatives. After mother's death patient found herself entirely alone in the world, as her father was also dead, and her younger half-brother (from father's second marriage) was not known to her and had dropped from sight of relatives. Patient had been employed for many years by a large concern in Boston, then had taken a position in a very prominent club because of easier working conditions. Is there now. Income, $16 a week. Rent, $4.50 a week. Patient is a native of Massachusetts, has a legal settlement in Boston. Father's health was good physically, but poor mentally. No definite diagnosis was known to patient.

Medical (Patient only)	*Social* (Family and patient)
	Mother had been well, but never very strong. Patient's health was good for years until onset of present illness. Loss of leg was due to accident when very young girl. Parents were both well educated. Patient has excellent education, well read on many subjects, especially interested in philosophy and various religious cults, although herself an Episcopalian. Clerical work of a nature which patient finds very interesting because it brings her in contact with persons of superior type. Work at first employer's had been tiresome because lacking in human interest. Father was suspicious and morose; had been unfaithful to mother; had violent temper; was lacking in concentration and purpose. Mother was a generous, fair-minded woman, loved her husband, but placed her daughter first; finally refused to condone father's faults because she feared their effect on patient. Patient is a thoroughly reliable and capable woman, well-bred, of pleasing appearance, dressed in good taste; is friendly, not a bit self-centered, eager to help others less fortunate than herself; very generous and with a high sense of responsibility about financial obligations; fond of speculating on abstruse, philosophical questions with a distinct leaning toward credulity in the matter of supernatural manifestations, but shows a lack of discrimination in working out her own philosophy of life which is a hodge-podge of

Medical
(Patient only)

Social
(Family and patient)

Theosophy and other Oriental cults, of High Church Episcopalianism, and of modern pseudo-scientific creeds.

b. *Treatment:*
   1. *Plan:* Readjustment of living and working conditions, supervision long enough to make sure that patient is able to get on alone and has confidence enough in social service to call for help if necessary.
   2. *Results:* Plan carried out; supervision relaxed some months prior to patient's death.

c. *Sources of information:*
Friends, employers.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Patient has an excellent L.M.D. who will supervise after discharge from ward.
b. *Hospital:* Such hospital care as is necessary will be given at M.G.H.
c. *Nursing homes:* Are desirable but too expensive.
d. *Convalescent homes:* Not suitable.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* Patient has no immediate family; she is intelligent, coöperative in treatment; character and temperament are both favorable to health. Home is one room in a lodging-house.
b. *Relatives:* No contact with relatives beyond one cousin, who will give a good deal of encouragement and friendly interest, but no financial aid.
c. *Benevolent individual:* There are several persons interested in patient who can give assistance.
d. *Private agencies and institutions:* One private agency of a specialized nature is available.
e. *Public agencies and institutions:* May be called on at any time.

NARRATIVE

Miss Edith Jenkins was a woman who would attract notice anywhere; first, because of her appearance, and then, because

of her character. She was tall, well-built, and of dignified carriage. While not beautiful if one analyzed her features, yet she gave an impression of beauty. Her hair was silvery grey, naturally wavy, and worn in a most becoming fashion. Her eyes were grey too, readily reflecting her moods; her skin was clear and ruddy. Her mouth had those lines around it which come to middle-aged faces which have always met life with a smile. Her manners were charming and conveyed an impression of resting on a nature which was friendly, affectionate and unselfish. Her taste in clothes was good. She looked what she was — a well-bred and intelligent woman.

Miss Jenkins had been in my ward some four or five days before she was brought to my special attention by one of her friends. This woman, who had known her only in recent years, could tell me nothing about her except that she had had a hard life and was now alone in the world except for many friends. It seemed advisable to several of these friends to ask Social Service to make sure that Miss Jenkins's convalescence was suitably planned, as her lodging-house was no place for her immediately on discharge from the M.G.H. I told my caller that I was acquainted with Miss Jenkins, but had not as yet seen any need of my services, although her diagnosis made me anticipate this later.

For several days whenever I talked with Miss Jenkins I guided the conversation into autobiographical channels, and, although she was asked no questions, she gave me a fairly clear outline of her history with the knowledge that I would report to the doctors on anything which I thought affected her condition. Her parents had been divorced when she was very young, her mother having been given custody of herself, the only child. Her father was ordered to pay alimony, but was negligent about it, and presently, when he remarried and had to meet the expenses of his new wife and several children, the first wife got practically none of the support to which she was legally and morally entitled. Mrs. Jenkins had a hard time, especially as she had no living relatives and her hus-

band's family blamed her for leaving him. They felt that, because he was so irresponsible, it was his wife's duty to put up with everything. Mrs. Jenkins, however, had felt that her first duty was to her child, and that it would be impossible to live with her husband without subjecting her child to unfortunate influence. For this reason mainly, she had decided on a divorce. From this time forward there was a complete estrangement between Miss Jenkins and her mother and her paternal relatives. As soon as my patient was old enough she went to work, but was greatly handicapped by the loss of one leg through an accident when she was about fifteen years old. However, she and her mother managed to be fairly comfortable until her mother's death. This was a terrible blow, as they had always been very happy together. Since she had been alone, now a number of years, she had lived in Boston and had visited her native city in western Massachusetts only within the last three years, her visits being to a distantly related cousin whom she had accidentally met and with whom she had developed very friendly relations. It was Miss Jenkins's intention to go to this cousin's home on discharge from the M.G.H.; just for a day or so, however, for she was sure she would be able to get back to her work within a week or ten days.

It was apparent to me that Miss Jenkins did not care to dwell on the accident which had cost her her leg, nor on the relatives who had neglected her and her mother. She did not blame them, as her father — now dead — had been a very lovable man, adored by his parents and sisters; but this very lovableness, it seemed to me, had been an additional hardship to the little daughter, who had grown into my middle-aged patient. There was still a wistful note when she spoke of him, although she could not forget her mother's ruined life. Her half-brothers had always ignored her. One of them was still alive, but where, no one knew. But, in spite of things which to many persons would have been very discouraging, Miss Jenkins held her head high and intended to do so whatever

came. She was well aware of her prognosis, knew she was liable to die at almost any time, and counted this a real blessing, since she had no money with which to take care of herself, and she was far too self-reliant to take help of any financial nature. Work had become her main interest in life; especially since she had left a large corporation to join the clerical force of a prominent club for men. Work she meant to stick to until she dropped at her desk.

Her physician was a member of this club. He had become interested in her as he saw her at her desk; it was he who had rushed her to the M.G.H. when she collapsed at work, and thanks to this, she was alive. His care would again be at her disposal when she left the Hospital.

After talking over with Miss Jenkins the conditions under which she worked and lived, I suggested that I see the steward of the club and attempt to readjust her work so that certain fatiguing elements might be eliminated. It seemed to me that if she could have her meals at the club, instead of having to go out to a restaurant, and if she could at the same time take a room in the street behind the club, she would be spared much fatigue and nervous strain. At present she lived at a distance which meant a twenty-minute walk morning and night. She had previously taken all three meals in a restaurant; hence, had also to walk there and back at noon.

Miss Jenkins, however, refused to allow me to rearrange matters for her because the steward, Mr. Brown, was 'a very hard man without sympathy for any employee,' and she was sure that any attempt to intercede for her would endanger her job. She finally agreed to my notifying Mr. Brown by letter of her condition and intended return to work very shortly. Her optimism in respect to this short absence from work I found was based on talks with the Visiting Physician, so I, of course, followed his lead. Later he told me that he was entirely unable to say when Miss Jenkins could get back to a normal life. He thought that such rearrangements as I suggested would be advisable, but that I need not be in a hurry about making them.

For a time matters drifted. Miss Jenkins had her good days when our daily chat was cheerful. She was well informed on many subjects, reading having always been her favorite recreation and her present position affording her access to an excellent library. Our talk ranged from ancient history to mental hygiene and pseudo-science, in certain features of which she was keenly interested; indeed, it took a good deal of consciously directed conversation to influence her toward reliance on strictly medical treatments. I thought her inclination to resort to another type of treatment might easily lead to disaster if it were used instead of her nitro-glycerine pills.

Good days, however, were often succeeded by bad nights. After one of these I wrote to Mr. Brown, at Miss Jenkins's request, that her absence was likely to be prolonged after all. Presently the physicians, to whom I had reported on the social data, told Miss Jenkins that the only possible way in which she could expect to continue in her work was to follow their suggestions about her room and meals; so she gave me permission to talk with Mr. Brown. I found him appreciative of Miss Jenkins and anxious not to lose her, since a well-bred woman was a great asset in the particular position which she held. My suggestions were well received. He called in the head waiter and the supervisor of the kitchen department to talk over ways and means. The question of a room was practically settled at once, since the supervisor owned a lodging-house in the street back of the club and there was a room vacant. This room I reserved pending Miss Jenkins's final decision. Mr. Brown promised to send a representative to the Hospital to talk with Miss Jenkins about her salary which would necessarily be readjusted if meals were to be furnished her. I came away from the club with the conviction that Miss Jenkins had been in error in her estimate of Mr. Brown; calm and dispassionate he was, and rightly so in his position, but to me he certainly did not seem hard or indifferent to the welfare of his employees.

Things worked out smoothly along the above lines. Miss

Jenkins, after several weeks with her cousin, returned to her work and got on very well. Of course she had attacks of pain, but nothing beyond what she could bear without coming into the ward. Finally, not quite nine months later, she had a severe attack and was brought to the Hospital in the middle of the night. In the morning when I arrived, I hurried at once to the ward. But I was too late, Miss Jenkins had died not five minutes before. Her cousin had been with her; by chance she had come to spend a few days with her only the night before. Some time later I learned that Miss Jenkins's brother had claimed her body. He had been notified by a relative who had known how to locate him; this relative had learned of Miss Jenkins's death through the devoted cousin. The funeral was held from the cousin's house and was attended by many of the relatives.

I have often thought about the various elements involved in this case and have regretted that I could not have been the means of bringing Miss Jenkins's brother and relatives to her before her death; especially, because the brother was so ready to come forward when he could give her no comfort. But I had not been willing to sacrifice the principle of not going against a patient's wishes unless to do so means beyond any doubt permanent and real benefit for the patient. I had, and have, no such conviction here.

COMMENT

How many persons are going through life estranged from their kinsfolk, lonely in sickness and in health, because of a social situation which a person of good social judgment might adjust? If there had been someone to show the older generation of the Jenkins family what they were doing when they cut off the son's divorced wife and daughter; if the sons of the second marriage and the daughter of the first could have been brought together during the lifetime of the latter, how much more life might have meant to her! Is not such a case one reason for advocating the presence of a skilled social case

worker in all courts of divorce, to at least *try* to prevent the sundering of ties, both marital and familial? Many judges endeavor to do this now, themselves, but without much success, for they have too little time. Is not the position of such judges a good deal like that of the hospital doctors of twenty years ago before the latter had social workers to assist them? The courts of domestic relations have already established the precedent (if any is needed) of social workers in such positions.

E. W.

'Clerical' work (in a men's club) which patient finds interesting because it brings her in contact with persons of 'superior type.' This motive or consideration in the choice of work and in sticking to it, often despite small wages and long hours, is sometimes not given the consideration that it deserves by social workers, vocational advisers, and economists. The bits of conversation by the way, the manners and the consideration of those about one, have often a crucial importance in deciding whether one likes one's day's work and finds life agreeable. There is no good reason for disapproving such choices or for urging the bare economic motive, as we are prone to do. To make a good living while leading a miserable life is not always the path of wisdom or of virtue. Nevertheless, in a case like No. 12 the desire for pleasant surroundings in one's work seemed to have blinded the husband to considerations even more important.

On the other hand, it is often enraging to see hospitals and colleges paying less than the market price for services because they can get people to accept pleasant surroundings in lieu of fair wages. This is one of the striking instances of social unrighteousness on the part of philanthropic institutions. Other similar outrages are the neglect of old-age pensions, proper rest rooms for women, and decent housing conditions by great philanthropic and educational institutions well known to the writer.

R. C. C.

CASE 7

ARTURO MARTINI Age 41 *Married*

Admitted to ward February 17, 1923. Discharged March 3, 1923.

MEDICAL SOCIAL PROBLEM

Syphilis of heart; dependency on public support; medical follow-up of family.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Syphilis of heart; aneurysm of the aorta with aortic regurgitation.

b. *Prognosis:*
Very poor; patient cannot work; will probably require bed care. Duration of life possibly not more than a year.

c. *Treatment:*
Symptomatic therapy; patient to report at Cardiac Clinic if he can.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient and wife are peasants, natives of Southern Italy; Roman Catholics. They have been in the United States about nine years. They are the same age. They have three children (one daughter and two sons) who were born in Boston and are respectively five, three and two years old. Patient's earnings have averaged around $15 a week; present income is $10 a week from the Overseer of Public Welfare. Rent is $8 a week. Patient has a legal settlement in the State, but no local one. Health of wife and children is apparently good. Patient and wife are illiterate. Patient speaks fair English but wife commands only a few words. Children speak practically nothing but Italian. Patient has been a laborer employed in mixing cement for a building contractor. Patient is cheerful and friendly with a childlike reliance on those whom he trusts. Is an affectionate husband and father. Likes to work, but thinks the country owes him an adequate allow-

Medical
(Patient only)

Social
(Family and patient)

ance now that he is ill. Intelligence does not reach beyond the obvious daily requirements. Wife is energetic, a good housekeeper, fond mother, obedient wife; not quick mentally — clings obstinately to ideas once received. Firmly convinced that she has a right to public support equalling the amount of patient's earnings because patient is unable to work. Children are obedient friendly little things who do not appear to be cleverer than their heredity would lead one to expect.

b. *Treatment:*

1. *Plan:* Send patient to public chronic hospital if he wishes to go; if not, supervise at home. In latter case get him to clinic if possible. Confer with Overseer *re* adequate allowance based on medical report. Have wife and children examined for question of infection.
2. *Results:* Patient supervised until he died. Wife and children examined and brought under treatment. Overseer supplied with medical data and asked to increase aid.

c. *Sources of information:*
Overseer, neighbors and friends.

2. Therapeutic Assets

Medical

a. *L.M.D.*: City district physician will go in if necessary.
b. *Hospitals:* Chronic hospital is available.
c. *Nursing homes:* Are too expensive.
d. *Convalescent homes:* Are not suitable.

Social

a. *Family and patient:* Patient has good attitude toward treatment; his disposition will help. Wife can be guided and advised in caring for patient physically but not much can be effected in other ways.

Medical

e. *District nurse:* May be called in if needed.

Social

b. *Relatives:* There are no close relatives in this country. Cousins can give no help beyond friendly visiting. Friends and acquaintances, who are mainly neighbors, are interested and sympathetic, but unable to do much beyond interpreting and accompanying patient to clinic.

c. *Benevolent individual:* None is interested.

d. *Private agencies and institutions:* Other than M.G.H. are not available.

e. *Public agencies and institutions:* Public chronic hospital will admit at any time. Overseers' aid is available now and Mothers' Aid will probably be granted later.

NARRATIVE

Mr. Martini had been in the ward ten days when the doctor first asked Miss Carrington to plan for chronic care for him. He was ready for discharge as soon as it was decided where he was to go — whether home or to a hospital for chronic cases. Miss Carrington inquired of the doctor about the necessity of examining Mrs. Martini and the children to rule out syphilis, but he said that this was unnecessary, as Mr. Martini's infection had occurred long before marriage, so that there was practically no chance of his wife and children having acquired it from him.

Having secured all the medical information which she needed, Miss Carrington sat down by her patient's bed and entered into general conversation with him, which she led toward the subject of his after-care. She found that he knew something about the public hospitals maintained by the State and city, and was quite willing to go to either one.

That afternoon at the visiting hour, Miss Carrington talked with Mrs. Martini. The latter was at first inclined to object

to her husband's going away from home, but said that he was the one to decide, and whatever he wished to do, she would agree to. Later on, Mrs. Martini returned to Miss Carrington to say that she and her husband had talked it all over and had decided that it would be better for him to go to the hospital, one of the chief reasons for this decision being the impossibility of providing suitably for him at home on the allowance of ten dollars a week received from the Overseers of Public Welfare.

Plans were made, therefore, for Mr. Martini to enter the State Hospital two days later. When the time came, however, he suddenly told Miss Carrington that he had changed his mind and was going home, having already notified a friend who had an automobile to come for him. Miss Carrington made no objection to this plan and accordingly saw Mr. Martini off, an hour or so later, promising to call on him soon at his home.

A few days later she went to see the Overseer who had charge of the family. Mr. Hunter agreed that the ten dollars allowed the Martinis each week was not enough if it was really their only income; but he was sure that they were hiding resources of some kind from him. Until he could clear up this doubt, he had not been ready to increase the allowance, but now, since the Hospital gave so bad a report on Mr. Martini's condition, he would ask for Mothers' Aid to be given, which meant a more liberal allowance based on the incurable illness of the bread-winner of the family. Mr. Hunter spoke highly of Mrs. Martini whom he considered a capable housekeeper, as her children were always neat and clean, her house in good condition, and meals, seen by him from time to time, were well-cooked and appetizing as well as nourishing.

Miss Carrington took an early opportunity of calling on her patient, but missed him, as he had just started off to see her at the Hospital. The kitchen, in which her interview with Mrs. Martini took place, was a pleasant, sunny room, evidently at one time a bedroom in this old house which had

once housed a single family in comfortable circumstances, but which now harbored four Italian families of the laboring class. The Martinis occupied the third floor, which gave them a kitchen, a large bedroom and a tiny one adjoining it. The furniture was an interesting combination of cheap modern things without any particular character and old articles unmistakably of Italian peasant origin. The beds, comfortable and clean, were gorgeous in their American brass frames and their Italian spreads. A good sewing machine was the pride of Mrs. Martini's heart. She proudly showed Miss Carrington her home and then called in a neighbor to interpret for her.

The three women and about half a dozen children settled down in the kitchen. Miss Carrington, who intended to guide the conversation carefully toward the medical and social problems of the Martini household, began by inquiring how it was that Mr. Martini, undeniably so ill, had had strength enough to go to the Hospital that morning. She learned that he went precisely because he was so ill that he needed a doctor. At the Hospital he had had many doctors who had helped him very much; since his return home he had had no doctor and no medicine and he felt, consequently, that he was not having what he needed. An attempt to make Mrs. Martini understand that one reason why her husband had felt better at the Hospital was because he was constantly in bed and had suffered no fatigue, met with little success. The relation between well-being and plenty of physicians was firmly fixed in Mrs. Martini's mind and was not lightly to be uprooted by a mere social worker whose real function was not even dimly apprehended by Mrs. Martini. Miss Carrington tried to explain her work by referring to Mr. Hunter, the Overseer, as also engaged in social work, but she made a great mistake in doing this, for at once there rose a torrent of Italian which flowed over and around the interpreter, who finally summarized it as a demand that Miss Carrington see to it at once that Mr. Hunter give much more generously of the public funds. Miss Carrington assured Mrs. Martini that she

had already talked with Mr. Hunter and believed that he would shortly give more aid. After this point was settled, it seemed best to withdraw for the time being, so, leaving behind her a card with her name and telephone number so that she could be summoned at once if needed, Miss Carrington returned to her Hospital.

Mr. and Mrs. Martini did not seem to resent their visitor's ignorance of their language. Whenever she came to call they were really glad to see her. When she explained over and over again why she could not give a larger allowance — although she could and did furnish medicine freely, when it was ordered — no malice was borne because of her lack of versatility. Her patient regained a considerable degree of strength and comfort, especially after a course of anti-syphilitic treatment was given at the clinic.

When this was decided upon, Miss Carrington consulted the physicians about the examination of Mrs. Martini and the children. It was planned that Mrs. Martini should be examined whenever convenient, although the examination of the children was not requisite. Miss Carrington awaited a favorable opportunity and then persuaded Mrs. Martini to come to the clinic with her husband. By this time the trusting little woman was ready to do as her 'social worker lady' asked. Still, she saw neither rime nor reason in it, although the germ theory was carefully explained, prevention as against cure was dwelt on and the result of non-treatment in Mr. Martini was pointed out.

Much to everyone's surprise Mrs. Martini was found to have the infection and treatment was started immediately. Then the children were brought in — all three had strongly positive tests, so treatment was begun at once, wholly as a preventive measure, since no ill effects had as yet manifested themselves. In many persons there would have been a painful reaction to this situation, but Mrs. Martini was not disturbed, for, of course, infections do spread in families. She was not afraid because she saw how much the treatment had

helped her husband. And it was carefully explained to her that none of the family was in a condition which was dangerous to others. Of course, she did not realize what disease this was that had infected all of them, that is, she did not know it unless her husband told her, because no one at the Hospital did. At all events, neither Miss Carrington nor the social worker in the clinic ever saw any indication of Mrs. Martini's knowing what the disease was nor in what manner she and the children had acquired it.

Within a month of Mr. Martini's discharge from the Hospital, the financial situation in the family became satisfactory. The Mothers' Aid Department began giving an adequate allowance, and the Overseers' aid was withdrawn.

For a year and a half Mr. Martini distinctly held his own. Then his condition changed. The wards were open to him, but he preferred to stay at home. In spite of all that could be done he died, twenty-one months after he first entered the Hospital.

The health of Mrs. Martini and the children was looked after successfully in several respects for some year or two after Mr. Martini's death. Miss Carrington's official connection with the case ceased, as the State Mothers' Aid Department carried the social responsibility and the social worker in the clinic at the Hospital supervised the medical treatment as long as this was necessary. But she occasionally saw Mrs. Martini, who looked on her as a trusted friend, with whom there was no need of formality.

COMMENT

This case demonstrates the fact that with syphilitic infections it is never safe to assume that the family of the original patient have not been infected. Of course, in circumstances like these, where marital unhappiness might have resulted from the discovery that the husband had communicated his disease to his wife and children, one must proceed with great caution. Nevertheless, sooner or later a complete examina-

tion of the family must be brought about. In this instance, four human beings were rescued from what might have been very serious after-effects. It would not, however, be correct to assume that in many families with a similar medical history, so many patients would have been found. The Martinis were unusual in this respect as well as in the degree to which the disease had affected the wife and children, the gross damage being potential rather than actual.

E. W.

The difficulties of carrying on social work in a family whose language and habits of thought are foreign to the worker are often much greater than would appear from the story of this case. Some of the worst failures that I have ever known in social work have been in cases where the worker supposed herself to be getting, through interpreters and through her own observations, an understanding of the situation sufficient to base intelligent and useful work on. Ultimately in these cases it has turned out that the worker had no idea of the real situation, of the client's state of mind, of the waste of time, money and effort involved. We should work for a state of things in which social work for recent immigrants is done either by intelligent and well-disposed members of their own race, or by an American who knows their language and has studied their history, traditions and mental attitudes with prolonged and sympathetic attention. Such was the work formerly done by Miss Hull among the Sicilians in the North End of Boston.

R. C. C.

CASE 8

JAMES MORTON Age 50 *Married*

Admitted to Male Medical Clinic July 11, 1919. Referred to Social Service the same day.

MEDICAL SOCIAL PROBLEM

Arterio sclerosis; cardiac disease; chronic alcoholism; dependency on wife, herself not fit to work; very meagre income.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Arterio-sclerosis; cardiac disease; chronic alcoholism.

b. *Prognosis:*
Probably can never again do any work, although there is no imminent danger of death.

c. *Treatment:*
Patient is to report at clinic as ordered; is not to work; is to limit activities to what he can bear without fatigue.

d. *Additional medical history secured by social worker:*
Patient has been a heavy drinker for years; has been inmate at State Hospital for Mental Diseases and Home for Inebriates.

Social
(Family and patient)

a. *Analysis:*
Patient and wife are natives of Great Britain; Episcopalians. Patient came to the United States as a boy of eighteen; entered domestic service where he met wife, who was in the same work. Married when he was twenty-four and his wife thirty-four; they have never had any children. Patient always a poor worker; quite ready to let wife support him. Latter is a hard worker and inordinately proud of patient. Left him once because of his intemperance, but returned in a few months. Patient was in Hospital for Mental Diseases six times for varying lengths of time, from a few weeks to a year; also treated at Home for Inebriates. Physicians said his mental trouble would disappear if he gave up alcohol. Couple have drifted around more or less, generally in or near Boston where they were known to various social agencies because of sickness and poverty. Wife was at one time examined by an alienist because of increasing

Medical
(Patient only)

Social
(Family and patient)

peculiarities, but no mental disease was found. Her general condition has always been below par. Income has varied, but generally has been below sum necessary to maintain health; has been supplemented by social agencies from time to time. Patient and wife not naturalized, but have legal settlements in Boston. Both have considerable degree of education; better command of spoken than written English. Wife's handwriting is very poor, but her choice of words and natural mode of expression are good. Patient has been a butler, janitor, and gate-tender; wife is an accommodator by the hour. She likes her work because of the people she meets. Patient is conscious of his good appearance and is vain; his even temper, affable manner and sunny disposition cloak great selfishness. Is fond of wife to whom he defers in everything, but shrewd in playing on wife's emotions. Wife is honest, hard-working, self-sacrificing, amiable to a fault, considerate and obliging; has uneasy nervous manner as of one over-anxious to please. Sensitive on score of age because she feels that it reflects on patient to have married a woman ten years his senior. Both patient and wife are grateful and appreciative, but averse to 'charity.' Have good manners; are innately courteous.

b. *Treatment:*

Supervision over four and three quarters years. Medical treatment arranged as indicated.

Medical (Patient only)	*Social* (Family and patient)
	Wife comforted and advised. Money raised for sending her away for a rest; new home found for her; belongings packed and moved. Wife helped through difficult readjustment and restored to self-support.
	c. *Sources of information:* Social agencies; employers; church.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Cannot afford to employ a physician.	a. *Family and patient:* Wife is devotion itself; is very skilful in looking after patient. Patient's selfishness will make him coöperate in treatment; his disposition will also help. Home is an attic room without heat. Income is below requirements.
b. *Hospitals:* M.G.H. is available for acute care; City Chronic Hospital will admit any time.	b. *Relatives:* None on either side.
c. *Nursing homes:* Are too expensive.	c. *Benevolent individual:* Several of wife's employers give them aid.
d. *Convalescent homes:* Not suitable.	d. *Private agencies and institutions:* F.W.S. will supplement the income; M.G.H. and other medical agencies will aid. Legal Aid Society may be called on for advice.
e. *District nurse:* Not needed.	e. *Public agencies and institutions:* Will assist at any time.

NARRATIVE

The doctor in the clinic, when he brought Mr. and Mrs. Morton to the social worker's desk to introduce them, said that he wanted an X-ray taken of Mr. Morton's chest. As the latter could not pay for this, would the social worker please secure it free? The doctor gave no prognosis beyond that Mr. Morton could not work at present, might never be able to, but there seemed no immediate danger. Whereupon Miss Warren talked with the Mortons for about half an hour and got a general insight into the situation. They lived in an attic room

without heat and had to carry water from the first floor. Because of a cough and general weakness, Mr. Morton had been unable to work for some eight or nine months; Mrs. Morton worked as accommodator in well-to-do families, earned thirty cents an hour, and received her lunches when she worked all day. But she averaged only between four and seven dollars a week, her receipts during the past week having been four dollars. Their savings that had been used to supplement her wages were now exhausted. There were no relatives on either side who could assist them.

It was at once apparent to Miss Warren that it was not only the savings which were in a state of exhaustion, for Mrs. Morton was the picture of it herself. Looking much older than her fifty years, emaciated, shabby though neat and clean, with big deep-set eyes which turned constantly to her husband and betrayed obvious terror about his health, she was the embodiment of all that makes bitter poverty in the old and infirm a thing which wrings the heart at one moment and at the next sounds the call to battle. Knowing that she had weapons with which to combat this poverty, Miss Warren set herself first of all to persuade her clients that they must let her do far more than provide a free X-ray. It took time because they did not wish 'charity' which they had had to accept in the past; they were sure that they could get along without assistance. Mrs. Morton said she ate very little, her one requirement being plenty of tea, and in the fall when some of her employers returned to the city she would have enough work to keep them going. She spoke at length of the great kindness of the ladies for whom she worked. Among other things they gave her clothes, especially articles for men, which meant that Mr. Morton was always dressed 'as one likes one's husband to be.' Then, if she worked only half a day, she was often told to have her luncheon before she left, in which case she would get the cook to wrap it up for her to take home, where she would share it with her husband, who relished these additions to his meals. 'One gets so tired of the things one gets at home.'

With Mr. Morton sitting before her, very well-dressed, sleek and well-fed, not obviously ill, Miss Warren had no manner of doubt that he did enjoy these meals and probably all others to an extent not shared by Mrs. Morton. It was apparent that Mr. Morton deferred to his wife in every way because she was much cleverer and could always devise ways and means to make him comfortable. Finally, by representing to Mrs. Morton that she must take better care of herself for her husband's sake, Miss Warren got permission to ask the Family Welfare Society to give some aid.

During the next two months Miss Warren and the District Secretary of this society kept in close touch with the Mortons. Miss Warren gave to the doctors the pertinent facts which twenty-five years' acquaintance with the Mortons had recorded in the files of the Family Welfare Society. Mr. Morton had been a hard drinker for years, had been in several hospitals for mental diseases (once for an entire year), had taken treatment at a Home for Inebriates without benefit, and had for years claimed to be too ill to work, relying on his wife's devotion and courage to provide all he needed. Mrs. Morton, always a little peculiar, had been examined by an alienist, but was declared not insane. Mr. Morton had been arrested several times, for assault and battery on his wife, for drunkenness, and for obtaining goods on false pretenses. He had never served time in jail, however, as fines had been assessed or the case put on file. After the last of these episodes Mrs. Morton had left her husband for nearly eight months, but since her return had been as devoted as ever. (Miss Warren felt that this could be easily understood, since Mr. Morton, when not under the influence of liquor, was a pleasant person with whom to live, a good example of the type of man who holds a woman's affections in spite of serious character defects because he possesses many of the small graces which make life go more smoothly.) Mr. Morton's last commitment to the Hospital for Mental Diseases was the year before prohibition went into effect. Since then he had behaved very well

if one discounts his not working and his selfishness. Some material aid and more or less constant advice and sympathy had been given by the Family Welfare Society.

The District Secretary and Miss Warren coöperated in trying to persuade Mrs. Morton to see a physician at the Hospital because she looked extremely ill. Even with the aid going in from the Family Welfare Society, she did not seem to be able to pick up in weight or color. She was in a constant fever of anxiety about her husband and when he was sent into a ward for study she fairly haunted Miss Warren in her attempts to find out how matters were progressing. She now confessed to Miss Warren that she had lied about her age, which was sixty instead of fifty; she thought it cast a reflection on a man of twenty-four to marry a woman ten years his senior, so, although he was aware of her age, she had always concealed the truth from others, even if not consistently so, as she sometimes said she was four or five years older than her husband. She declared that her conscience had been troubling her about deceiving Miss Warren.

During this especially trying season Miss Warren tried to get Mrs. Morton to have an examination, but she always had an excuse. To her apparent physical disability was added a mental one in that her behavior became quite erratic; she repeated the last four or five words of every sentence and seemed unable to grasp what was said. She was deaf to words of reassurance about her husband whose condition was said by the doctors in the ward to be not at all serious. To her, the fact that he was in bed meant real illness; in vain did Miss Warren and the doctors explain that he was in bed because his case was being studied. At last, after much persuasion, Mrs. Morton came into the clinic, where she was found to have varicose veins in her legs and to be in generally poor condition. Bandages for the legs were ordered and she was given a tonic; attention to hygiene was also recommended.

After Mr. Morton was discharged from the ward, he reported regularly at the clinic. Light work was recommended

and a gate-tender's job was obtained for him by the Family Welfare Society. Milk was sent in by the same agency, ostensibly for Mrs. Morton, but when she was asked directly how much she drank of it, she acknowledged that she took very little, as she wanted her husband to have it. Glasses for Mr. Morton were provided and other attempts made to keep him as comfortable and contented as possible. Then, as the medical situation did not require supervision by a hospital social worker, and as Miss Warren had been transferred to another department, which meant that a different social worker would have had to carry on the case, the record was closed by Miss Warren's successor, who left the Family Welfare Society in sole charge.

For over a year Mr. Morton was faithful in attendance at the clinic; his condition was satisfactory and he worked a few hours daily. From time to time he was seen in the clinic by Miss Hargrove, Miss Warren's successor, who helped him in various ways, as with free admission and medicine. The Family Welfare Society continued to take an active interest in the couple. Then Mr. Morton was again sent into the ward because of arterial spasms; ten days in bed put him in much better condition and greatly relieved the pain in his legs. However, after discharge, he did not do well at home and finally took to his bed. Once more he was admitted to the ward; in about ten days his condition had changed so much for the worse that the doctors advised amputation of his leg as a last resort. Mrs. Morton was distracted and refused to consent, both because of her fear that her husband's cardiac trouble was so serious that he could not recover from the operation and because she could not tolerate the idea of mutilation of her handsome husband.

Miss Hargrove, Miss Warren — now in the House Social Service — one of the hospital chaplains, himself an English clergyman, all labored with her, but she would not give in. As for the doctors' fears about gangrene, she refused to believe in any such contingency. All this time her husband,

racked by terrible pain, was entirely willing to have his leg off, but, as he was delirious part of the time and as his wife gave instances of how confused was his mental state, the Hospital refused to operate without Mrs. Morton's consent. For nearly two weeks the struggle to persuade her to agree to the amputation went on; only her husband's visible failure finally won her over. The leg was taken off, but it was too late. Six days later Mr. Morton died.

The Family Welfare Society appointed a new District Secretary at this time. She realized that because she was a stranger to Mrs. Morton, the latter would probably find more comfort in Miss Hargrove's visits than in hers. So she withdrew from the case.

Hospital social workers — especially those in the wards — are of necessity constantly working with persons who are in great distress and sorrow, who are prostrated by bereavement, but not often are they called on to cope with such anguish as that of little Mrs. Morton. For over a month after Mr. Morton's death she would not go to bed at night, but sat up, napping a little, in her chair. Her room was in wild confusion; she had had no courage to sort out and dispose of Mr. Morton's clothes, which were strewn everywhere. Miss Hargrove, who was kindness itself, was greatly disturbed by the physical discomfort and mental agony which Mrs. Morton was bearing. The latter's employers were unremitting in their attentions, which included a decent outfit of widow's clothes, and of course her friends at the church did everything possible. The funeral expenses totalling $150 were met through an insurance policy in the church burial society.

Finally Mrs. Morton was persuaded to go to a convalescent home where she stayed three weeks. During this time the landlady decided she needed Mrs. Morton's room for her own use. Since Mrs. Morton absolutely refused to move, legal advice was taken, in accordance with which Miss Hargrove tried to get Mrs. Morton to allow her to engage a room for her. Failing in this, Miss Hargrove arranged for her to go, upon

discharge from the convalescent home, to the home of one of her employers for a time. After several weeks there, she yielded to Miss Hargrove's remonstrances and allowed the latter to remove her belongings from the room and put them in storage, as now no other room could be found.

Due to all this anxiety Mrs. Morton lost all the benefit from her stay at the convalescent home. She was deeply discouraged and saw no reason why she should try to live. Several of her employers were seen by Miss Hargrove; they made a gift of fifty dollars for Mrs. Morton's benefit to be spent at Miss Hargrove's discretion. The first thing done was to get Mrs. Morton into another convalescent home out in the country. Here she began to improve slowly but surely. In about a month Miss Hargrove installed her in a new room in a house where the landlady was sympathetic and considerate.

Mrs. Morton now resumed her work and, although at times terribly discouraged, she kept on going. At the end of four months she had become entirely self-supporting. Miss Hargrove still had thirty dollars left of the fifty dollars, but Mrs. Morton liked to feel that she had this in reserve for a time of greater need and would not hear of using it then.

Occasionally she dropped in to see Miss Warren, to whom she could not say enough in praise of Miss Hargrove, while at the same time she was solicitous not to hurt Miss Warren's feelings by comparisons, outright or implied. Gradually Miss Hargrove and Miss Warren could see that Mrs. Morton was improving; there came a day when she met Miss Warren on the street and proudly displayed a new hat with a very long crêpe veil which had just been given her by an employer, who had bought it for herself at an exclusive shop, for her own use, and was now passing it on as good as new to Mrs. Morton. The latter's heart was thrilled at the thought that she could wear mourning from that shop for her beloved husband.

Miss Warren understood and sympathized with this feeling and wondered if she had been making good use of this very natural feeling in dealing with her own patients. To many a

loving widow the outward symbol of her bereavement is a necessity.

Miss Hargrove kept on, here gaining a point, there conceding one (temporarily); it took months of time, many home visits, several of the most persuasive (not to say cajoling) letters to get new glasses for Mrs. Morton. After the latter had worked steadily for a year, a vacation was suggested — in vain. The thirty dollars was still in Miss Hargrove's hands and seemed likely to remain there indefinitely. When Miss Hargrove was going on her vacation nearly two years after Mr. Morton's death, his widow came to see her and presented her with a box of candy from a very popular shop. She was far from well, so Miss Hargrove tried to make use of this visit by having a physician see her, but it could not be done in the face of Mrs. Morton's opposition, although she confessed that she was spitting blood.

Miss Hargrove is still watching carefully, ready when she is needed, but things are at a standstill just now. Almost five years have gone by since Mr. and Mrs. Morton were first referred to Miss Warren, during which time there has hardly been a month when either the Family Welfare Society or the hospital social worker has not been working on the case. If one thinks of social work only in terms of material things, as so much free medicine, so many grocery orders, so much money raised, the work done in this case bulks very small. But if there is a deeper and wider understanding, if helping human beings face and accept the inevitable disasters of life as well as its petty annoyances is recognized as the real test of what a social worker accomplishes, then the case of Mr. and Mrs. Morton will appear to the laity as it does to the professional worker as at one and the same time the justification for social case work and the reason why its practitioners are able and willing to bear their burdens.

COMMENT

One of the outstanding features of this case is the fact that a

number of different social workers participated in it without impairing each other's influence with the clients; a most difficult task because it is only natural for clients to like some of us better than others and to be guided more easily by the one they prefer personally. Moreover, one sees clearly that it was guidance, not domination, which Mr. and Mrs. Morton received. They were shown the way, but they were not driven along it. They were free agents (or as nearly so as anyone is) even to the point of exercising poor judgment which really proved disastrous, although as a matter of fact Mr. Morton was doomed in any event, the only hope being that of deferring the end.

The work which went into reinvigorating Mrs. Morton after her husband's death is perhaps the finest thing in the entire case.

E. W.

Pressing financial aid on those loath to receive it would have sounded like strange doctrine to the charity workers of the last generation. The habit has grown up perhaps too easily with coming of medical-social work because in such work one meets again and again those cases of genuine uncomplaining, half-unconscious poverty which are so much rarer in work of the 'Family Welfare' or 'Associated Charity' type.

But there is another reason. The zeal for health which the medical-social worker catches from the doctors and nurses around her makes her ready to take a risk of some 'pauperization' for the sake of a future supply of healthful energy and happiness which, she is confident, can overcome some temporary demoralization.

Further still, there is the belief that money given for health is much less demoralizing to the recipient than money given for other reasons.

Despite all these good reasons one wonders sometimes whether social workers are not too 'easy' in giving or urging others to give money for hygienic bonanzas which may not materialize, or only to a very limited extent.

R. C. C.

TUBERCULOSIS

(Eleven cases)

NOTE

Case 9. *Edward Bradley:* æt. 28.
Tuberculosis of spine with prolonged recumbency; no financial resources except earnings of wife.

Case 10. *Lucia di Goma:* æt. 18.
Tuberculosis of spine with prolonged bed care; unfavorable housing.

Case 11. *Robert Lavalle:* æt. 13.
Pulmonary tuberculosis with diabetes and cataracts; poverty; broken home; deportation impending.

Case 12. *Elizabeth Dubois:* æt. 33.
Tuberculosis with pregnancy; infection of children; irresponsible husband; inadequate income.

Case 13. *Elizabeth Young:* æt. 37.
Pulmonary tuberculosis with pregnancy; infection of child; ample resources.

Case 14. *Paul Duval:* æt. 20.
Pulmonary tuberculosis with tuberculous colitis; paralysis of leg; meagre financial resources; poor family spirit.

Case 15. *Catherine Reilly:* æt. 17.
Tuberculosis of hip; inadequate income with partial dependency on relatives; unfavorable family history.

Case 16. *Rose Gore:* æt. 13.
Peritoneal tuberculosis; ample financial resources recently acquired.

Case 17. *Harriet Carleton:* æt. 17.
Pulmonary tuberculosis; pleurisy with effusion; trachoma; deportation.

Case 18. *Gertrude Smith:* æt. 41.
Renal tuberculosis with involvement of bladder; sanatorium care; no money; no relatives; public aid.

Case 19. *Patrick Callahan:* æt. 38.
Pulmonary tuberculosis; desertion of family.

NOTE ON SOCIAL WORK WITH TUBERCULOUS PATIENTS

Work with heart disease has almost no relation to legislation. Work with tuberculous patients, on the other hand, is closely bound up with social legislation. The social worker must be familiar with the laws pertaining to the supervision and treatment of tuberculosis; she must understand something of public health work and be able to coöperate with the public agents, her knowledge of the powers entrusted by law to the Boards of Health keeping her from overstepping her boundaries and encroaching upon the activities of the health officer and the public health nurse.

This knowledge is important, too, in dealing with the patient, to whom the legal right of the health authorities to take action should be explained at an early moment. For if he does not understand that cases of tuberculosis must be reported to the Board of Health and that their agents will visit his home, he is likely to resent what will appear to him an unwarranted intrusion and to believe himself a marked man henceforth to be watched carefully to prevent his injuring others. On the other hand, if he realizes that the State is so acting to make sure that he has access to the care provided by law, he will take a more sensible view of the proceedings.

The medical-social worker must, of course, be well grounded in the medical phase of the problem. She must be able sometimes to suspect the symptoms in persons who are not aware of any trouble more serious than that of being tired and 'run down' and persuade them to seek medical advice at once. She must inquire particularly into the health of those with whom her patient comes in contact. She must give special attention to children who have been exposed to contagion, aiming to bring these children to par if they are below it; supervising them, in any event, long enough to make sure they do not fall ill as a result of exposure. She must guard against fear and discouragement on the one hand and on the other against that undue optimism that is founded on a false sense of well-being.

In some communities, the nurses of the Board of Health take over the responsibility for the social treatment of the tuberculous patient and his family; but almost always the medical-social worker may, if she wishes, work out with the nurse a plan involving joint action. For example, if the patient is the bread-winner of the family, support must be provided for them through public or private resources.

It is generally agreed that the ideal treatment during some phases in the course of all cases of tuberculosis is sanatorium care, and since the provision of adequate facilities to this end depends upon the general recognition of the fact, public opinion must be guided toward its adoption. The social worker should do her part in this. Immersed in details of practice, the social worker is prone to lose sight of her duty in the larger aspect, namely, that of contributing from her experience and knowledge to the development of a sound and informed public opinion. In the discussion of the treatment and supervision of communicable disease, her voice is especially needed.

CASE 9

EDWARD H. BRADLEY Age 28 *Married*

Admitted to Orthopedic Clinic April 12, 1918. Referred to Social Service October 17, 1918.

MEDICAL SOCIAL PROBLEM

Tuberculosis of the spine; prolonged recumbency; no financial resources; wife obliged to become bread-winner.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Tuberculosis of spine with impending paraplegia.

b. *Prognosis:*
With surgical treatment seems fairly good.

c. *Treatment:*
Bone graft operation should be performed as soon as possible.

d. *Further medical history obtained by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient was born in Portsmouth, New Hampshire, of Irish parents; is a Roman Catholic. Wife, a native of Massachusetts, of English descent, has become a convert to her husband's religion. Only child, a daughter, was born in New Hampshire. Family have lived in present home for seven years. Have had an uneventful life until patient became ill about a year ago. Wife and daughter have always had good health. Patient has earned about $20 a week. Rent is $3.50 a week. No savings. No insurance except a small death benefit. Patient has a legal settlement in town where he lives. Patient and wife have fair education; have better spoken than written English. Daughter is in public school. Patient was formerly a boilermaker; for past eight months has been driving delivery automobile for a laundry. Wife before marriage worked in a factory to which she has returned

Medical (Patient only)	*Social* (Family and patient)
	since patient's illness. Wife's earnings have risen from $8 to $18 a week — ultimately to $21. Patient is courageous, optimistic; energetic and a steady worker; talkative and amiable; devoted to his family; faithful to his treatment. Wife has many of the same qualities. Her devotion to patient and readiness to support the family have reënforced his courage and determination to keep on with treatments. Daughter is too young (eight years) for much judgment to be passed on her character, but she gives no trouble.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: An excellent L.M.D. is much interested and coöperates with clinic in fine spirit.	a. *Family and patient:* Fine family spirit; patient has excellent attitude. Comfortable home of six rooms up one flight; affords ample opportunity for patient's recumbent care. Devotion and intelligence of wife when supplemented by Board of Health nurse will insure his proper care.
b. *Hospital:* M.G.H. is available for acute stages of patient's illness and for treatment at clinic.	b. *Relatives:* There are relatives on both sides who can do much to help in other ways than financial; they are unable to give money.
c. *Local municipal hospital:* Will give chronic care if necessary.	c. *Benevolent individual:* None interested.
d. *Nursing homes:* Are too expensive and also not so stimulating to patient as is his home.	d. *Private agencies and institutions:* Family Welfare Society is available.
e. *Convalescent homes:* Are not suitable.	e. *Public Chronic Hospital and Public Relief Agency:* May be called on to help at any time.
f. *District nurse:* Is not available because of diagnosis. *Tuberculosis Nurse from Board of Health* will supervise patient at home.	

NARRATIVE

When Edward Bradley first became acquainted with Miss Jackson, the social worker in the Orthopedic Clinic, he was facing what he knew was a serious problem. He needed an operation which would entail months of hospital care and further months of very slow convalescence; a probable change of work would be necessary. He had no money. For the past year he had been working irregularly owing to ill-health. Debts had piled up and he had been obliged to apply to the Overseer of Public Welfare for aid during one period of total inability to work. Lately he had been somewhat better and had managed to work enough to pay off most of his debts, though he was still several months in arrears with the rent. To help clear off their indebtedness, his wife had recently insisted on getting a job in a factory where she earned eight dollars a week. They had relatives who were sympathetic and generous, but not in a position to give substantial aid. Excepting his mother-in-law none was closely related to the family.

Mr. Bradley's physician had sent him to the M.G.H. because the specialized surgical treatment he needed could not be furnished by the local hospital. The general nature of the operation had been explained to Mr. Bradley by his doctor. And he was perfectly willing to undergo it even though he thought it involved amputation of one of his fingers to supply bone for grafting in his spine. Miss Jackson explained away this erroneous idea; and then talked over plans for carrying out the doctor's orders, which were as follows: bone graft in spine, necessitating probably eighteen weeks in the ward; recumbent care at home in a plaster cast for about four weeks longer, to be followed by visits to clinic at intervals of about a month for an indefinite period during which he would continue in a cast until he was ready for a brace. He would be incapacitated for work for at least six months, probably longer.

Mr. Bradley proposed giving up his tenement and sending

his wife and daughter to her mother's home for the period of his illness and convalescence; after which they would take a smaller and cheaper tenement. He was sure his wife would be able to earn more as she acquired more skill. Acquiescing in this plan for the future, Miss Jackson took him to the Admitting Superintendent to talk about his operation. The latter told him that it was the Hospital's policy to reserve free treatment — as far as possible — for those who had no local hospital where they had a legal right to obtain it. It was suggested to Mr. Bradley that, since he came from a city supporting a municipal hospital, his local Overseer of Public Welfare should be asked by him to pay for his treatment at the M.G.H. Mr. Bradley accepted the justice of this policy and agreed to act accordingly. He went home to await Miss Jackson's summons to come in for his operation.

Miss Jackson was still awaiting a decision from the local Overseer about paying the hospital bill when she received a letter from Mr. Bradley saying that he thought he could pay ten or fifteen dollars on admission to the ward and would promise to pay the balance when he got back to work. He asked if the Hospital would accept this arrangement. A week later, the Overseer wrote that he could pay bills for patients in the local hospital only. He recognized the distinction between the types of treatment given by various hospitals, but the city's policy did not take this into account. Under these circumstances the Admitting Superintendent told Miss Jackson that Mr. Bradley could be admitted to the M.G.H. on his promise to pay for his treatment whenever he could. Miss Jackson at once reported this to Mr. Bradley, who came into the ward very soon thereafter.

After careful observation, the surgeons decided against operating at that time, preferring first to try the treatment of complete rest in bed in a cast. This decision was accepted very well by the patient, who now thought it best to keep his tenement and try this treatment at home. His wife was making twelve dollars a week and further raises in pay were ex-

pected, so he was sure that they could get on all right. Miss Jackson was a little disturbed, however, because her patient was so obviously undernourished. He was shabby, too, and she was sure that poverty had had much to do with his condition. However, after talking it all over with Mrs. Bradley it seemed best to let the couple decide for themselves the question of asking the Overseer for help at this point.

During the next few weeks Miss Jackson wrote occasionally to Mr. Bradley encouraging him to keep on with his treatment. A month after he left the ward, he reported at the clinic showing marked improvement. He was not so thin, his color was good and he looked like a different man. His native humor was much to the fore again. He said he had not felt so well in ten years. Things were going on well at home. His wife was now getting fourteen dollars a week and as her work was near by she always came home at noon; thus the question of his care was comparatively simple.

Mr. Bradley's condition was so favorable that the doctor promoted him from the rigid plaster cast to a leather jacket for which he was measured at once. The cost was twenty-five dollars, which sum Miss Jackson undertook to provide. As the doctor said Mr. Bradley could work when the jacket was ready, which would be in about six weeks, he was tremendously encouraged. (This optimism was unhappily not justified by the course of events.) His employers were ready to give him a suitable job whenever the doctors allowed him to return to work.

Miss Jackson applied to the local Family Welfare Society for information about any available fund on which to draw for Mr. Bradley's jacket. In reply she received a letter from the Supervisor of Nurses of the local Board of Health, to whom the Family Welfare Society had sent her letter. The Supervisor promised to help in every possible way and asked for more details. These Miss Jackson at once supplied in a letter; she explained that she had not thought of asking the Board in the first place, as there was no legal obligation to provide for other than laryngeal and pulmonary tuberculosis.

From then on for more than a year Miss Jackson had constant help from the Board of Health nurse. Together they worked to improve the home, which while clean was marked by clutter and confusion. The Bradleys took every criticism in good part, realizing that it was part of the treatment. The improvement was very noticeable.

Mr. Bradley gained ground steadily, especially after he came into the ward for a few days to have his leather jacket fitted. He then spent months flat in bed fully aware that this was imperative if paralysis were to be prevented. At the request of the M.G.H. a local physician was sent in once a month by the Board of Health to determine whether Mr. Bradley could begin to sit up a little. Although there was a possibility of being in the local tuberculosis hospital during this period of recumbency, he and his wife begged to be allowed to try it out at home and events proved that it was wise to try this plan, for orders were scrupulously carried out under supervision of the Board of Health nurse. The psychological effect on both Mr. and Mrs. Bradley was undeniably good. Their spirit was remarkable; always cheerful and courageous, they looked forward confidently to the time when Mr. Bradley could once more resume a normal life.

Early in June, after three months of recumbency and three weeks during which he was up a short time each day, Mr. Bradley reported at the clinic. The doctors thought that now an operation could be risked. Mrs. Bradley, who was earning by this time seventeen dollars a week, readily undertook to pay seven dollars a week for her husband's care at the M.G.H., her sturdy sense of self-reliance insisting on this arrangement. She was to have all the time she needed for paying the bill.

Mr. Bradley was more than ready for the operation. Indeed, he said he was willing to have his head taken off if it would help! No vacancy occurred, however, in this ever-crowded ward until the first week in August. The operation was then successfully performed; approximately seven weeks were spent in the ward and then Mr. Bradley returned home.

Every one in the Hospital who came to know this rather quiet, pleasant-faced, friendly man loved him and regretted his departure even though glad with him that it was possible. He was to continue wearing his leather jacket and report at the clinic in one month. In the meantime, the Board of Health nurse would supervise.

About two weeks after Mr. Bradley went home, Miss Jackson called but found no one in; so she wrote him asking for a report on his condition. No answer was received. Then, since Mr. Bradley did not come to the clinic at the proper time, Miss Jackson wrote to the Board of Health nurse who reported that Mr. Bradley was at work! He had gotten on so well after he left the ward that at the end of four weeks he had gone back to his old job. The nurse, on receipt of Miss Jackson's letter, persuaded him to report at the clinic in a day or so.

Mr. Bradley came in according to his promise and upon examination was found to be in excellent condition. He walked with a firm, strong tread and was in buoyant spirits. He said that in returning to work he had only followed out the orders given him in the ward, as he understood them. His employer was exceedingly kind; he had given him an assistant to carry the heavy packages, although he still had some lifting to do. He had a route which covered outlying country districts, and his trips were quite long, but he did not find driving the car too fatiguing. His wages were twenty-five dollars a week and his wife was getting twenty-one dollars. She was so interested in her work that she would not hear of giving it up. They hoped to pay the hospital bill very soon. After that they were planning to save money. They were looking forward to a period of prosperity and happiness. When he left the clinic he promised to come again in two months.

But, alas, for promises! It lacked only a few days of one year when Mr. Bradley was next seen in the clinic. Letters had been sent in vain. The employer had been appealed to and he had urged the patient to visit the clinic. The Board of

Health nurse had tried her best, but without success. Mr. Bradley's attitude seemed to be: 'I am feeling quite well, so why waste time?' In spite of Miss Jackson's continued efforts, the clinic might never have seen the runaway again if he had not overreached himself in his exuberance. He lifted his kitchen stove one day with the result of immediate trouble in his spine. He stuck it out at home three weeks, then was brought into the Emergency Ward of the M.G.H. by the Board of Health nurse.

A plaster jacket was applied and he remained in the ward overnight while Miss Miller, now the social worker in the Orthopedic Clinic, tried to plan for the recumbent care which the doctors were ordering for an indefinite period, probably for at least a year. It was difficult to arrange this, especially as Mrs. Bradley was out of work owing to a shut-down of the factory. Mr. Bradley finally agreed to enter the local tuberculosis hospital, his wife took a position in domestic service, and the little daughter went to live with relatives.

This arrangement lasted only a few weeks, however, when the family was reunited at home, the Overseer having allowed sufficient financial aid to enable them to do this. The patient improved rapidly at home, thus justifying the doctor at the tuberculosis hospital who had advised his return home.

Five months elapsed, during which time the invalid kept faithfully to his treatment. Then he once more entered the M.G.H. ward for another operation. This time he stayed two months. On his discharge he was referred for supervision at home to the same excellent physician who had coöperated the year before.

For ten months things went fairly well. Mr. Bradley learned to make little wooden toys at home, which entertained him, and brought in a little money, too, for Miss Miller sold them for him. He was in bed for eight months, then was allowed up a short time each day. Unfortunately, he developed a respiratory infection which put him in such poor condition that fourteen months after his second operation a third

one was necessary, as a new focus of infection had developed. After this operation he was ready for discharge in six weeks.

Again there was a new social worker in the clinic, Miss Moore, who planned with Mr. Bradley for his after-care at home. The Board of Health nurse assisted Miss Moore in arranging his return home in an automobile rather than stretcher and train as before. He was to be flat on his back for four weeks, then try sitting up. One would think that by this time courage and optimism would have departed, but not from Mr. and Mrs. Bradley. They faced the situation just as bravely as when they had begun on the long course of treatment now nearly three years ago. Even when five weeks after this third operation sudden paralysis came on, they were not dismayed. Mrs. Bradley was working again and Mr. Bradley had quite a lot of toys on hand which some of their friends were going to raffle off, so that the financial needs were fairly well covered.

Miss Moore visited several times, carrying instructions and encouragement from the doctors of the clinic who believed that the paralysis would disappear. Absolute rest in bed was insisted on at first, then gradually the patient was allowed to exercise his legs very slightly, still lying flat in bed. The local physician was again called on, the Board of Health nurse of course visited regularly, and by means of close coöperation Mr. Bradley was brought safely through the winter in spite of some pleurisy. A wheel chair costing seventy dollars was provided by a church club on its own volition, long before Mr. Bradley was able to use it. But even the *sight* of the chair no doubt helped to encourage him.

Eleven months after the third operation Miss Moore got her patient into the clinic. He remained overnight in the Emergency Ward for X-rays. A plaster jacket was applied and a new leather one ordered. The spine seemed firm, but the legs were still somewhat spastic, so the doctors ordered Mr. Bradley to sit up only a short time daily and not to walk until he had his leather jacket. At this time Mrs. Bradley was

earning eighteen dollars a week, the Overseer was giving four dollars a week, and a cousin was paying four dollars a week for the care of his small daughter who was living with the Bradleys. Mrs. Bradley thought she could repay the cost of the leather jacket in small weekly installments, but accepted gratefully the aid of the church club which responded gladly to Miss Moore's appeal for the thirty dollars it cost.

Again the weeks and months went by, bringing remarkable improvement to Mr. Bradley. Some six months later he began to walk a little. Very slowly his activities were increased until by the next spring, two years after the third operation, he was able to get outdoors and do the family errands. Brought to the clinic, he was found to be in excellent condition; his spine was healed and he had regained practically complete use of his legs. The doctors were immensely pleased; not only those who had actually worked on him, but the entire staff rejoiced.

Miss Moore talked over plans for the future and found that Mr. Bradley, always forehanded and energetic, already had the promise of a job as salesman which would mean driving around in an automobile. He needed no training for this work. He faced it so enthusiastically and eagerly, it made one think of a spirited dog held on a leash, straining to chase his quarry.

COMMENT

This case illustrates numerous points. In the first place, it shows successful work with a patient in spite of the fact that there were three different social workers in the course of the long treatment coöperating with eight different nurses under the local Board of Health. A *consistent plan of treatment* under the close supervision of the doctors made this possible. Again, it demonstrates a policy of the M.G.H. which has worked successfully — enlisting the services of a local physician or surgeon, the social worker forming the connecting link between him and the clinic physicians. Furthermore, it shows how

long-drawn-out medical treatment is made possible through the social service department of a hospital, by means of which a patient can be held to his course of treatment.

Finally the patient's own character and the devotion and courage of his wife counted so much in the whole matter that they cannot be omitted from an enumeration of helpful elements. Such qualities are of such undoubted therapeutic value, indeed, that where they are lacking they should be supplied even though artificially. 'Assume a virtue if you have it not.'

E. W.

Tuberculosis of the spine, which if neglected produces hunchback, has another danger, even when this deformity is prevented by lying flat and by the support of plaster or leather jacket. This second danger is paralysis of the legs due to pressure of the tuberculous disease on the spinal cord, that great bundle of nerves which runs down the back, hidden and protected within the hollow bony tube of the spine. This complication occurred in the present case, but was relieved. (Other complications are exemplified in Case 10.)

Bone grafting, the application of a splint of beef bone which supports and finally fuses with the backbone, greatly shortens the tedious process of lying for months and years on one's back until the diseased bone is healed. But the graft on spine is not equal to every strain and may snap off, as it did in this case. Orthopedic surgeons are not yet in agreement as to the field of application, the extent of utility, of these grafts.

R. C. C.

CASE 10

LUCIA DI GOMA Age 18 *Single*

Admitted to Orthopedic Clinic June 23, 1919. Referred to Social Service February 17, 1923.

MEDICAL SOCIAL PROBLEM

Tuberculosis of spine; prolonged bed care; home in congested tenement district; discouragement and despair.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Tuberculosis of spine with left psoas abscess.

b. *Prognosis:*
Prognosis is probably good with proper treatment and hygiene.

c. *Treatment:*
Hospital care until abscess is drained; thereafter patient to wear brace; hygiene to be improved.

d. *Additional medical history secured by social worker:*
None obtained.

Social
(Family and patient)

a. *Analysis:*
Parents are natives of Italy and are Roman Catholics. Parents have been in the United States twenty-four years spent almost entirely in Boston, where all of the five children were born. Parents have never learned English, but are very ambitious for the children; latter have been given as many advantages as possible, but the home discipline is typically Italian in the autocratic attitude of the father and the restriction of freedom for unmarried daughters. Family income averages $50 a week. Father earns 55 cents an hour; Albert $20 a week; Carlo $14 a week; patient $10. Rent is $21 a month. Father is not naturalized, but has legal settlement in Boston. Health of family seems to be good. Father reads and writes in Italian; mother is illiterate. Albert is a graduate of a four years' course at a good business school; was trained as bookkeeper. Carlo and married sister went through public grammar schools. All the children speak Italian. Father is a

Medical
(Patient only)

Social
(Family and patient)

laborer; Albert is a bookkeeper in a candy factory; Carlo is a helper on automobile truck. Father is a strong, muscular man, kindly in manner, affectionate toward family. Mother is voluble, cordial, bustling and efficient — a good house-keeper and cook according to her light. Both parents are especially fond of patient. They are self-respecting and intelligent and anxious to have children get ahead in the world. Albert is intelligent, voluble about himself, proud of his career at school and in business. Has standards of home comfort and expenditure beyond what circumstances warrant; clearly family leader. Carlo is a good son and brother, apparently less clever than Albert. Nothing definite learned about married sisters, but they are in close sympathy with family. Patient entered an institution for crippled children when eleven years old and remained there five years; reached the sixth grade; had average marks, excelling in penmanship and basketry, but low grades in effort and deportment. Left above institution against advice because she wanted to go to work. Speaks Italian. Not coöperative in medical treatment; refused to wear brace regularly because she said it disfigured her. Has worked as packer in bakery earning $10 a week. She is neat in appearance and habits; very fond of dress. Uncomplaining about sufferings, but inclined to disregard medical instructions

Medical (Patient only)	*Social* (Family and patient)
	such as those pertaining to hygiene.
	b. *Treatment:* Home visits; medical situation interpreted; family influenced in favor of suitable treatment. Supervision over sixteen months until another agency assumed control.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.:* Family unable to employ a good one.	a. *Family and patient:* Family spirit and devotion will do much for patient. Ignorance is no obstacle, since intelligence is present. Income is sufficient even without patient's wages. Home is comfortable, but below patient's standards; therefore depressing. Neighborhood is wretched. Patient has not within herself any positive assets, but will be susceptible to influence.
b. *Hospitals:* Acute and chronic private hospitals are available.	b. Relatives are factors of a minor degree.
c. *Nursing homes:* Highly suitable, but too expensive.	*Benevolent individual:* Group of young girls.
d. *Convalescent homes:* Not suitable.	d. } *Public and private agencies:* Both
e. *District nurse:* Can and will give very valuable aid.	e. } groups can supply help of various kinds.

NARRATIVE

In 1907 one of Boston's hospitals began to treat an Italian baby who had tuberculosis of the spine. She was only two years old and was the second youngest of a family of five. For about nine years she came to that clinic off and on, and then, when she was eleven, she entered a school for crippled children. No social worker knew her, so we have no information as to why she had not gone to this school sooner nor concerning what finally led to this important step. But the public school visitor may well have been the prime mover because

the school record shows that the visitor was sent to the home to talk with the parents about the child's diet, which was changed very willingly. During the first years spent at the institution for crippled children, Lucia was treated at the same hospital, but later, when she needed medical advice other than what the school afforded, she was brought to the M.G.H., Out-Patient Department, because by this time she was too old to visit the first hospital. The social worker at the M.G.H. Clinic was not called on by the doctors at the time Lucia was first seen. Some three and a half years later, after the patient had left the school and returned home, the physician in the Orthopedic Clinic asked Miss Moore, the social worker, to arrange for Lucia's admission to the ward for drainage of an abscess, the result of her spinal disease.

By this time the baby with whom we started in 1907 had developed into a very attractive girl of eighteen. Her clothes were of the most ultra-modern type, elaborate and gay, but she would not tolerate anything which drew attention to her deformed back. She had been working for about a year, although there was no financial pressure; her family simply recognized her need of an occupation if she were to be happy and forget her handicap. After having applied to a social agency which could not supply a suitable job, she had found her work for herself. It was not exhausting, for she could sit or stand as she chose. She loved being in the factory with other girls, and no wonder, for her home was not of the kind in which a young girl wishes to spend much time. The neighborhood was one of tenements. The streets were narrow, dirty, congested, noisy. The house was an old one, in bad repair, and with halls which were so dark that one could only feel one's way around. The rooms inhabited by the family were on the third floor; they were four in number, neat and clean and furnished in the style typical of Italian villages. The only modern thing was a radio set which played a large part in the family life. Lucia and her brothers longed for a home furnished in 'American style' in a pleasant suburban community. They

were bent on getting this and possibly might have succeeded before now had not Lucia's old illness broken out again.

Lucia came to the M.G.H. Clinic on this day in 1923 in considerable pain and yielded readily to the doctor's recommendation of immediate admission to the wards. But when Miss Moore undertook to arrange this, she found that there were no empty beds. There was nothing for her to do but to send Lucia to another hospital or back to her home, there to wait for a vacancy at the M.G.H. As the latter course was decided on, the doctor told Lucia to remain in bed under the care of the district nurse until Miss Moore notified her to come to the Hospital.

During the next ten days Miss Moore and the district nurse visited Lucia regularly; the sinus in her back opened and was dressed by the nurse in accordance with instructions obtained by Miss Moore from the physician. Attempts were made to improve the hygiene in the home, but without much success, though Miss Moore succeeded in moving Lucia from an inner bedroom with one window opening on a blank wall to another which, though smaller, had two outside windows. Though Lucia and her brothers dwelt on their desire for a better home, when Miss Moore suggested that this home might be obtained by degrees, that, for instance, a simple place with the old furniture, in a better neighborhood, was possible now, they would not agree. Since their ideals were not compatible with their present financial status, they insisted that there was nothing to do but wait until they had more money.

Time went on, but Lucia did not improve enough to get into the clinic nor did an opportunity occur for her admission to the ward. The district nurse and Miss Moore were distinctly uneasy at bearing so much medical responsibility which belonged properly to a physician. But at last they got their patient onto her feet once more and presently she came to the clinic. She was persuaded to wear a brace regardless of her appearance and there was a period when she was fairly

well. Then another abscess formed and the old weary treatment had to be gone through again.

When she recovered from this siege, Lucia went away to visit relatives at the beach, a suggestion of Miss Moore's about going to a convalescent home in the country not having interested her. When she returned home from the beach, six weeks later, a decided change for the worse was apparent. She was pale and thin, one of her legs gave her much pain and seemed to be gradually drawing upwards so that she could not bear her weight on it. Again the doctor advised Lucia to enter the ward, but the child was afraid. It took quite a bit of persuasion by Miss Moore, on her visits to the home, to overcome this fear. Perhaps her admission could never have been brought about except for the fact that one day a neighbor telephoned Miss Moore that Lucia had fever and was in much pain. Miss Moore at once consulted the doctors and then made arrangements for the patient's immediate admission, as there was, fortunately, a vacancy in the ward. So, almost before she knew it, Lucia was carefully transported from her home to the Hospital.

Some two weeks later, after the abscess had been opened, the doctors discharged Lucia as no longer in need of care in a hospital for acute cases. They wanted her to have two months in bed in some institution in the country. It was not possible to get this, however; once more Miss Moore and the faithful district nurse took up the burden of looking after Lucia in her home. Matters did not go well. Lucia became thinner and paler; the big dark eyes grew darker and bigger; she was in pain most of the time; her appetite flagged and her moods were as sombre as the November skies without.

To add to the family's troubles, work was scarce and the income was very uncertain. The question of sending Lucia to a nursing home where the expense would be at least eighteen dollars a week was carefully considered; it was obvious that the family could not pay for this, and Lucia's prognosis, now so poor that the doctors even thought that she might not live

through the winter, blocked the use of private funds. Since there is not enough money to care privately for both those whose condition is incapable of real improvement and those who can be restored to normal activities as self-supporting members of society, the latter are usually given the preference and the former made as comfortable as possible at home or sent to public institutions. Though it was hard to see Lucia languishing in her dark tenement home, still that was better than sending her to a public hospital for chronic cases where she would not be readily accessible to her family and friends, since this hospital was located on an island. Everything possible was done to cheer up Lucia; among other things a club of young girls was appealed to for friendly visiting. At Christmas she received a number of gifts, and she sent a box of candy to Miss Moore.

Lucia's condition went from bad to worse until finally Miss Moore decided that if the doctors could give any hope of real improvement, she would make application for her patient to a private hospital for chronic disease. One of the staff physicians visited Lucia in her home, after which the case was carefully considered by all of those concerned in the treatment of the patient. The course proposed by Miss Moore was then approved. She secured the family's consent and late in January sent in the application. Lucia was admitted in March. By this time she was a very wretched little girl. She was extremely uncomfortable, barely able to move, her temperature was swinging from 100° to 102°, her pulse was about 130. In deference to the patient's dislike to an ambulance, the drive to the hospital was made in a luxurious private automobile sent by a young girl who was interested in Lucia. Miss Moore, herself, accompanied her. Upon her arrival, she was put in a bed by a window which opened on a beautiful view; sunlight poured in, warm and fragrant breezes blew over her; it was like another world in contrast with the congested neighborhood of dingy tenements which they had left an hour ago.

Lucia's only objection was that the other patients in the ward were all much older than she, an objection for which Miss Wright, the social worker in the hospital, thought she knew a remedy. And sure enough, a few days later, Lucia was transferred to the Children's Ward, where she was entirely happy. Since Miss Moore's responsibility ceased when the medical control passed from her doctors to those at the chronic hospital, she withdrew, leaving Lucia to Miss Wright, having been careful to show Lucia her own entire confidence in and admiration for her colleague.

COMMENT

One notices at once how much medical responsibility is placed on the district nurse and social worker in this history, a responsibility not theirs, but unavoidable in the circumstances because of the long periods when the patient was not well enough to attend the clinic, but was not under other, closer medical supervision.

Is one justified in a suspicion that a real opportunity to build character was missed by the institution where the patient spent five years? One has a fear that the subsequent unfavorable course of the disease was due to Lucia's own defiance of what was advised because it drew attention to her deformity.

As in so many cases one is forcibly impressed with the need of good family case work in this family — *family* case work, whether done by a family agency, a medical one, or a school. By the time the medical social worker became acquainted with the case, it was too late to guide the children's praiseworthy ambitions toward an ideal capable of embodiment in a home environment which would have been so much better for the patient in every way. To eager, inexperienced youth half a loaf is not always better than none, but a social worker may be able to bring about the consumption of the first half of the loaf while waiting and working for the second.

E. W.

It must be recognized, of course, that although much was done to make this sufferer's life less wretched, the case is medically a failure. The disease is going on unchecked and in all human probability will lead to death.

R. C. C.

CASE 11

ROBERT LAVALLE Age 13 *Single*

Admitted to ward November 30, 1923. Discharged March 17, 1924.

MEDICAL SOCIAL PROBLEM

Diabetes and pulmonary tuberculosis in a young alien with no civic rights; poverty; broken home, fear, anxiety.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Pulmonary tuberculosis with positive sputum; diabetes mellitus; double cataract.

b. *Prognosis:*
Very poor because of double diagnosis, advanced stage of tuberculosis and patient's age.

c. *Treatment:*
Sanatorium care and insulin both imperative. Cataracts will be removed after patient has been built up by above treatment.

d. *Additional medical history secured by social worker:*
Minor details relative to name of physician and hospital in charge of patient prior to M.G.H.

Social
(Family and patient)

a. *Analysis:*
Mother is of French-Canadian stock, born in Quebec, and is Roman Catholic. Father, of same background, died when patient was six years old; mother has had hard time to support family. Came to Brockton, Massachusetts, with two older sons about four years ago leaving patient and younger sister with maternal uncle in Quebec. Mother earns about $8 a week; brothers earn $14 and $20. There are no savings. Mother has no settlement in Massachusetts; is still an alien. Children all share her status. Health of family is good. Mother has rather meagre education. Patient has done well in school where he has completed what corresponds to about the eighth grade. Mother works at cleaning by the day; brothers are employed in a shoe factory. Mother is devoted to children, is ready to follow advice; is not at all bashful about accepting any possible aid, but is really appreciative. Of brothers nothing

Medical
(Patient only)

Social
(Family and patient)

definite is known, but they appear to be hard workers with a good family spirit. Patient is a lovable child, shy, with sweet disposition, cheerful, uncomplaining, easily amused, affectionate.

b. *Treatment:*
   1. *Plan:* Place patient in an institution where he can have medical treatment for both diseases. Arrange later for operation on eyes; providing glasses free. Call in social agency for report on home conditions, finances, possible necessity of public aid.
   2. *Results:* Patient sent to State Hospital. Glasses provided free. Report received from local agency. Mother encouraged, advised, and taught.

c. *Sources of information:*
   Social agency, relatives.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Is powerless to treat because mother cannot buy insulin.
b. *Hospitals:* Hospital treatment is available.
c. *Nursing homes:* Will not admit because of diagnosis of tuberculosis; besides, are too expensive.
d. *Convalescent homes:* Not suitable.
e. *District nurse:* Not available because of diagnosis; the Board of Health nurse may be called on.

Social

a. *Family and patient:* Family home not suitable for patient. Income not sufficient to care adequately for patient unless at risk of undermining the health of the others. Family spirit is good.
b. *Relatives:* No relatives who are able to help.
c. *Benevolent individual:* No benevolent individual is interested.
d. *Private agencies and institutions:* Cannot meet situation alone.
e. *Public agencies and institutions:* Are available to a limited extent and can supplement the private ones.

NARRATIVE

ROBERT'S mother was left a widow with four children, and when she came to the United States in order to find work she brought with her her two older sons, and left Robert and his sister with an uncle in Canada. About four years later, the uncle sent Robert on to his mother in Brockton because of the boy's failing health and eyesight for which he could not receive the medical care he required, the farm where he lived being remote from all facilities. The uncle knew of the many institutions in the United States which provided help, but, like many other Canadians of the less educated group, had no idea as to political limitations. It did not occur to any of the family that the institutions of the neighboring country were not open to aliens on the same terms as citizens enjoy.

As soon as Robert arrived in Brockton, his mother sent him to a private hospital where for three weeks he was treated with insulin for diabetes. But the cost of this new medicine was too heavy a strain on his mother's purse, particularly in view of the fact that the shoe factory which employed her older sons had shut down temporarily; so Robert was removed to her home. This consisted of three rooms (for which she paid ten dollars per week) in a building which was so shut in by taller ones that the rooms had no sunlight, little ventilation, and were damp. Here Robert remained for several weeks, keeping to a diet list which had been ordered at the hospital, but without insulin. His appetite was ravenous, and the family, taking this as an evidence of undernourishment, plied him with the foods the diet allowed, but in dangerously large quantities. He declined rapidly, and Mrs. Lavalle, becoming alarmed, called in a physician who sent him to the M.G.H., believing hospital care was the only thing which could save him.

At this period, when insulin was scarce and expensive, the large hospitals had an enormous demand for treatment from diabetics who had been led to understand through incorrect

press reports that a man of great wealth had given these hospitals large grants to enable them to treat diabetics without cost to themselves. This impression came from an erroneous interpretation of a grant given for research and was the cause of bitter disappointment and even suffering. The M.G.H. was using the greatest care in ordering the new treatment so as to make sure that the patients could continue to buy the insulin, since, once begun, the treatment had usually to be kept up. This meant that diabetic patients were brought at once to the notice of the Social Service Department. And thus it was that Miss Warren was early made aware of the difficulties in Robert's path.

When it was discovered that the boy was also suffering from tuberculosis in an advanced stage, it seemed that these difficulties were insuperable. The recommendations of the doctors would have been hard to carry out even for a patient with a legal claim on Massachusetts; for an alien without such rights, the resources were indeed limited. Miss Warren was thankful that she need not make immediate plans, as Robert was to be in the hospital ward for some time while the necessary adjustment of diet to insulin was made. The surgical treatment of his eyes was not to be attempted until after the sanatorium treatment for his tuberculosis had had a chance to build him up.

Shall we say right here that this history has a happy ending? It will help to offset the pathos of the story as it opens. To the doctors, nurses, and social workers who saw Robert, he was altogether touching, from the moment of his admission to the ward. Small for his thirteen years, his still almost infantile face bearing an expression of sweet patience, thin to the point of emaciation, shut out from intercourse with others in the ward, not only by his blindness, but also by his ignorance of English, even without our realization of his bad prognosis, he was a most pathetic little figure. His case was hopeless unless by the use of insulin the diabetes could be brought under control and the treatment of tuberculosis made possible. Miss

Warren explained to the boy's mother that up to the present the doctors had been virtually helpless in cases like Robert's; for if the patient's diet was held down to the requirements for treating diabetes, he died of tuberculosis; while if he was fed the highly nourishing food necessary for a tuberculous patient, he succumbed to diabetes. There was as yet no available experience as to what insulin might be able to effect in a tuberculous diabetic.

Mrs. Lavalle responded in good spirit to the frankness with which the matter was put before her. She had faith that her boy could be helped at the Hospital, and even if he could not, at least he was having such care as she could not give him at home. Her attitude toward the social investigation was the same. Although she, too, had believed the newspapers correct in reporting that diabetics would be supplied with insulin free, she accepted the explanation of the error given her. When she understood that, in order to give Robert the long period of after-care necessary, public aid would have to be invoked, she made no objection. She was ready to accept help from any source open to her.

When the insulin began to relieve Robert of his severe headaches and general apathy, it was exceedingly difficult to find amusement for him in that he was blind, that he spoke no English, and that his Canadian French was hard to understand. Wherefore, to begin with, Miss Warren asked the hospital chaplain who visited the boy whether it would not be well to call in a priest from the French Church with whom he could talk more freely. The chaplain agreed and sent for a curate from the church near by.

Noise appealed to him as to most children, and he took delight in whistles, mouth organs, and other musical toys presented to him, though their use was necessarily restricted because of the condition of others in the ward. Then someone had a bright thought and a penny bank was presented to him. So many people were interested in Robert that his fortune grew apace; over and over he counted his pennies from one

hand to the other. Soon he began to count in English, helped by a kindly old man in the bed next to his. Circumstances alter cases; and though no social worker would ordinarily favor this plan as social therapy, Miss Warren approved of giving pennies to Robert and was prepared to defend her opinion.

As Christmas drew near, every man of the twenty-two in the ward became keenly interested in Robert's stocking. The doctors, nurses, medical students, the social worker, and those she had called in to help entertain him — all tried to make sure that this little lad had a happy holiday. Something unforeseen, however, proved better than all the rest. On the 24th of December, it was decided suddenly to operate on one eye, reversing a decision which had postponed any surgery for some time to come. On the day after Christmas, when Miss Warren visited Robert to inquire how he had fared, he told her that he had wonderful presents, but that what the operation had given him was the best.

Then there came a day when Robert looked at Miss Warren out of one eye as she approached and, before she had time to say anything to him, called her by name. Shyly he explained to her that he knew her by her voice which he heard as she spoke to another patient. He was allowed only a brief peep, then the watchful nurse covered up the eye again.

Robert stayed in the ward for three months and a half. Both his eyes were operated upon with successful results, owing to the improvement brought about by insulin. His general improvement was great; his face filled out to such a degree that he seemed like another child. He learned to chatter in English, and a peculiar charm was imparted to his speech by his use of medical terms picked up in the ward.

During all this time, Miss Warren had the assistance of a colleague in Brockton whom she had called in to help with the family situation. Together the two social workers labored to prevent a rash move on the part of Mrs. Lavalle, who suddenly took it into her head to leave Brockton to join a sister

who was working in a factory in another city. There was no prospect for work for the family there and the sister could not support them. Indeed, there was no reason for any such departure excepting vague uneasiness on Mrs. Lavalle's part. It was true that the financial situation was not wholly favorable; but with Mrs. Lavalle's steady earnings of eight dollars a week, with the part-time work which one of her sons presently found, and with free medical treatment, both present and to come, it was possible for the family to get along without asking for public aid.

Finally the time came for planning for Robert after his discharge from the Hospital. He could not be admitted to the State Sanatorium for tuberculous children because his legal status was that of an alien without a settlement and because no sanatorium was equipped to treat a patient needing insulin. The General State Hospital, however, was available; but it took time and patience to obtain the consent of Robert's mother to allow him to be sent there. Miss Warren explained to her that Robert was liable to deportation at any time as a public charge, as soon as his condition made it safe to send him back to Quebec. The authorities, however, would act generously as well as justly; and meantime the main thing to be considered was the medical treatment. After that had been secured, it would do no harm if the boy went back to his uncle for a time. Mrs. Lavalle agreed to his going to the State Hospital.

When he was discharged, Robert had nearly five hundred pennies. His mother had told him how expensive the medicine he had to take was, and he offered his money to Miss Warren to pay for the insulin. Miss Warren made him feel that the Hospital wished him to have the pennies for himself.

Mrs. Lavalle went with Robert in the ambulance and train to the Hospital and was pleased with all the arrangements. She reported later that Robert's tears over leaving the M.G.H. were soon dried in his interest in his new surroundings.

Miss Warren, who had given the Social Service Department

of the State Hospital a summary of the case, urged Mrs. Lavalle to rely for advice and help in the future upon the case worker there who was in charge of Robert.

During the next eight months, Miss Warren heard frequently from Mrs. Lavalle. She reported that the glasses sent to Robert about six weeks after he left the Hospital enabled him to see clearly; he went to 'the movies' provided by the Hospital; he played games with the other patients; soon he was allowed to be out of doors. Both clinical and X-ray evidence witnessed the improvement of his lungs, and the social side of the matter was equally satisfactory, for the routine deportation proceedings had been postponed at the request of the Social Service Department of the State Hospital, leaving Robert in peace to continue his treatment until such time as he could be sent back to Quebec without danger.

At the end of Robert's seventh month in the institution, the Superintendent wrote Miss Warren that he had gained twelve pounds; the insulin needed was now only eighteen units daily (he had had as much as seventy-six at the M.G.H.), his cough was gone, and the pulmonary tuberculosis was at least quiescent. His vitality was such that he told his brother he wanted a good fight with him!

The physicians at the M.G.H. acquainted with the case thought his condition gratifying and considered his prognosis much improved.

Although the social worker at the State Hospital has the social responsibility, and will make plans for Robert's return to the community, Miss Warren will follow up future developments. She dares to hope for yet fuller recovery for Robert.

COMMENT

This unfinished case points so clearly to certain conclusions as to justify presentation. In the first place, the social worker put in a great deal of time and strength in securing for her patient what the physicians wished him to have, although it seemed to many concerned that the situation was hopeless.

The child had the adult type of tuberculosis; he had severe diabetes; his age was against him and the social circumstances were unfavorable. Wherefore, it would have been simpler to give up hope, let his mother take him home, and concentrate all social effort in making him comfortable for the short time before him. The other course was chosen, however, and has already justified itself to a certain degree. One cannot, of course, assume that Robert will live to manhood; but he has a good fighting chance. Moreover, he is happy and so is his mother. Further, the latter has not the bitter consciousness she might have had that, with all the resources Massachusetts has to offer, there was none to help her child because she was an alien. She and her children intend to remain in this country; but even if they were not to do so, it would have been well that they should have realized that there is no unjust discrimination against foreign-born residents of the United States, even when they have not become citizens.

From the medical point of view, the case is interesting because of the new factor which insulin introduced into the situation. There was much discussion concerning the inability of sanatoria to carry out insulin treatment. The case also caused renewed discussion concerning the provision of the law under which sanatoria operate which excludes aliens in favor of citizens. Although at first thought, this may seem unjust, upon further consideration it is seen to be based on the fact that the citizens of the State support these Sanatoria by taxation. Since the beds are few in proportion to the needs, it seems right that citizens should be given precedence. It should be noted, moreover, in this connection that aliens are not all those who are not citizens, but those who have not the legal settlement acquired by five years' residence in a specific town or city of Massachusetts. Even the citizen is subject to the settlement laws in this respect.

The State of Massachusetts has, however, one medical institution, the State Hospital, in which anyone may receive treatment. It is a good hospital, though one which is not

generally understood by the public. It, too, is supported by taxation. Any alien treated there may be deported if he is within the time limit set during which aliens who have become public charges may be returned to their country of embarkation. Greatest care is taken, however, to insure the operation of the law in such a way as to avoid hardship to the patient.

E. W.

Children in hospital wards with adults are almost invariably spoiled by them and have a hard time of it when it comes time for them to leave and to face the less exciting and easy conditions of home. Sick adults are hungry for the sight and sound of children and lavish on them such wealth of attention that their egotism is rapidly developed.

Short visits by children to hospital wards of sick adults are a Godsend to the latter, and often do them more good than the drugs and ministrations of nurses and doctors. But a long stay in such wards should never be permitted to a child — especially during convalescence when he is apt to be allowed to stay long after he is quite well.

R. C. C.

CASE 12

ELIZABETH MURRAY DUBOIS Age 33 *Married*

Admitted to ward February 21, 1921. Discharged March 13, 1921.

MEDICAL SOCIAL PROBLEM

Pulmonary tuberculosis and pregnancy; irresponsible husband; inadequate income; very young children.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Pulmonary tuberculosis with no bacilli in sputum; tuberculous pleurisy with effusion; pregnancy of six months.

b. *Prognosis:*
Is exceedingly bad.

c. *Treatment:*
Hospital care until confinement; thereafter sanatorium care if patient survives confinement.

d. *Additional medical history secured by social worker:*
Patient was never very strong; constantly undernourished since marriage; has lost steadily in vitality.

Social
(Family and patient)

a. *Analysis:*
Husband is a native American born of French parents; patient is native Canadian of Anglo-Irish stock. Both are Roman Catholics. Patient has been in the United States about nine years. Was a well-paid secretary before marriage four years ago. This is her third pregnancy, the first resulting in a miscarriage and the second in the birth of a son, Charles, now twenty-two months old. Family have lived in several New England cities according to where husband has found work. Latter was drafted in army during World War seeing service in France, but escaped without injuries, in fact with improved health. Income is $12 a week plus two meals a day for husband. Rent is $16 a month. Family have legal settlement in Boston. Husband has perfect health. Charles has a tendency to 'colds,' is well-developed and well-nourished, but is pale and under weight for age. Husband has average public school educa-

Medical
(Patient only)

Social
(Family and patient)

tion; patient has greater degree of education. Husband operates an elevator and occasionally helps on the telephone switchboard in a clubhouse. Husband is amiable, courteous, careful of personal appearance, afraid of anything approaching hard work; anxious to work in pleasant surroundings even though pay is less. Does his work to satisfaction of employer; thoroughly self-centered; affectionate toward patient and son, but never to a degree where he forgets his own comfort. Irresponsible on score of financial obligations. Cheerful, receptive toward assistance of any kind. Patient is a self-sacrificing wife and mother; has great patience and forbearance, sweetness and courage, sturdy sense of responsibility, no desire to shirk or to obtain more than her due. Affectionate and highly appreciative. Intelligent, but not sufficiently keen to analyze her husband's character and to understand the connection between this and her own illnes

b. *Treatment:*

1. *Plan:* Carry out doctor's order for patient; supervise as long as necessary. Have husband and son examined to rule out tuberculosis; reenforce husband's character.
2. *Results:* Patient's needs met. Supervision of family given for eleven months, during which time medical and social treatment was provided with indifferent success. No apparent effect on husband's character.

Medical
(Patient only)

Social
(Family and patient)

c. *Sources of information:*
Benevolent individual; relatives; other medical and social agencies.

2. Therapeutic Assets

Medical

a. *L.M.D.:* Is not needed.
b. *Hospitals:* Lying-In Hospital and a private endowed one for consumptives are available; public sanatoria are not.
c. *Nursing homes:* Are too expensive. Not available because of tuberculosis.
d. *Convalescent homes:* Are not suitable.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* Home is a three-room tenement in fairly good neighborhood, but quite unsuited to patient's needs. Husband will not hinder, neither will he help in treatment. Patient's courage, her concern lest family contract disease, and her strong desire to get well will greatly help.
b. *Relatives:* Patient's sister cannot give financial aid, but will comfort and sustain her and do all which husband and his family will permit in caring for Charles. Patient's parents in Canada can do nothing. Husband's parents will give husband and Charles a home, although not without board being paid. They will not be of any assistance with patient.
c. *Benevolent individual:* A member of the club which employs husband is very much interested; has put patient in free bed in Hospital; is paying all extra expenses and will give further assistance, both financial and in visiting patient; if possible, also in influencing husband.
d. *Private agencies and institutions:* May be called on if necessary.
e. *Public agencies and institutions:* Can give only a limited service because of laws governing treatment of tuberculous patients and also because of legal settlement.

NARRATIVE

WITHIN forty-eight hours of Mrs. Dubois's entrance into the ward, and before the complete diagnosis had been made, Miss Warren felt sure that her help was going to be needed. Mrs. Dubois was prostrated, and she knew so little how to take care of herself and of the resources for prenatal care offered by the community, that while she waited for the doctors to finish their study of the patient, Miss Warren was making her preliminary plans. Her patient, slender, fair-haired, with blue eyes and a wistful expression, was a shy young woman with a serious outlook who soon revealed a capacity for self-sacrifice that is not common.

Miss Warren was on friendly terms with both Mr. and Mrs. Dubois before the doctors were ready to confirm their suspicion of pulmonary tuberculosis as the dominating factor in the patient's condition. The diagnosis came as a shock to Mrs. Dubois, though her husband accepted it coolly. It required a great deal of explanation and persuasion to convince her that she must remain in a hospital at least until her baby was born, and very possibly longer. She was not told of the grave danger of her death soon after the confinement. The doctors felt it so probable, indeed, that they did not advocate a therapeutic abortion, judging that the patient was already beyond help from this measure. The obstetrical consultant advised concentrating on the effort to safeguard the baby, allowing Mrs. Dubois to go to term, or as nearly so as possible, in an attempt to terminate the pregnancy naturally. This plan was in accordance with the religious principles of the family and met their approval.

It became evident very shortly that Mr. Dubois would evade decisions and all other responsibility whenever possible. He relied upon his wife and mother to make the necessary arrangements, confining his efforts to setting the seal of his approval upon such plans as were likely to cause him least trouble. His parents had taken little Charles when his wife

went to the Hospital, and he readily agreed to give up the tenement and go himself to live with them. For ready money, he substituted promises to pay, disregarding the facts that he could not save a penny of his wages, that he had no prospect of an increase of pay, and that he was in debt for his furniture and for the excellent clothes he wore. Suggestions that he seek work which would bring in more money were rejected. His present job suited him exactly; the surroundings were delightful, the meals excellent, and his associates agreeable; why change for mercenary motives? Besides, somebody always came to the rescue. Already, indeed, a member of the club where he worked was deeply interested and was helping. It was through him that Mrs. Dubois was enjoying the privileges of a free bed at the Hospital; and further benefits were to be expected from the same source.

The problem of such selfishness in a man of twenty-eight seemed hopeless; but Miss Warren determined to grapple with it as soon as she should have found a suitable place for his wife. She secured admission for her in an excellent little private hospital specializing in the care of consumptives. Treatment was to be furnished free, the Superintendent agreeing with Miss Warren that Mrs. Dubois must be cared for even though her husband shirked his responsibility. The patient was installed in a delightful private room and settled down contentedly to build herself up for the sake of the baby. Visits from her husband, her sister, who was a clerk in a local shop, her mother-in-law, and Miss Warren kept up her spirits and reassured her as to her little boy, who was not brought in to see her. Miss Warren gave her the report of the examination of her husband and child at the Out-Patient Department which quieted her anxiety lest they be infected with tuberculosis also. Naturally, Miss Warren did not tell her that the grandmother hadn't received in good spirit the doctor's orders as to Charles's diet. She didn't see any reason in changing it to suit modern ideas, nor would she agree to bring the child to the clinic as recommended. But the doctors said there was no cause for alarm,

though they wished to see the child regularly at the clinic.

Gradually Mrs. Dubois lost ground, though she did not realize it, being constantly in bed so that she did not note the increasing weakness. Miss Warren arranged for her confinement at the Lying-In Hospital, where in due season her baby was born. The child, a girl, was apparently normal and healthy, though it weighed only six pounds and was very thin. From the moment of its birth, the mother had no contact with it, only seeing it occasionally from a distance; and at the end of two weeks she was sent back to the Consumptives' Hospital, while the baby went to its grandmother. The latter had been very reluctant to assume the care of the second baby, and Miss Warren had tried to get Mr. Dubois to make other plans for it; but events moved more rapidly than his mental processes, and while he was still trying to decide what to do, the day arrived when little Ruth had to leave the Hospital. A twenty-four-hour supply of modified milk was sent with the baby, together with the formula for making it. Miss Warren made connections with the nurse at a Baby Hygiene Station near by and impressed upon Mr. Dubois and his mother the necessity of following instructions to the letter.

Days and weeks passed, and still Mr. Dubois made no pretense of paying the bill at the Lying-In Hospital, which he had agreed to meet at the rate of one dollar a week for forty weeks. To all suggestions and propositions, he replied courteously that he would, of course, as a man of honor pay his debts, but until he received a greater income he could not make any more payments. He claimed that his wages were now apportioned as follows: eight dollars a week to his mother for the care of the children and a bed for himself, and four dollars a week to the firms which had sold him the furniture and clothing. He refused to give the names of these firms or the sum he still owed them. He would not even consider selling the furniture, which was of expensive make and in excellent condition, although he knew his wife was dying, and although he had declared more than once that he would have no home of his own for a long time to come.

Secretly, Miss Warren and the Superintendent of the hospital where Mrs. Dubois was, challenged that statement; for of late Mr. Dubois came less frequently to see his wife, and his visits were brief, while his appearance became ever more dapper. These experienced ladies discussed these social symptoms and made a diagnosis, keeping it to themselves, however, for of what avail was it at the moment? But their indignation increased when the patient, becoming delirious in her ravings, disclosed privations she had suffered since her marriage. Her sister, who had suspected that she had borne what pride had caused her to hide, was heart-broken at having her suspicion confirmed. It was touching to witness her grief and anxiety, but Miss Warren urged her in vain to spare herself.

The one consoling feature in this long-drawn-out struggle for life was that the patient never realized its significance until the very end. Her religious adviser, one of those splendid examples of the Christian ministry of all sects with which hospitals are blessed, was in daily attendance, keeping her prepared for death in such a way that she did not suspect it. Thus she was spared up to the last minute the agony of knowing that she had to leave her husband and children. Her baby she never saw after she left the Lying-In Hospital; but Charles was brought in to her a number of times, in spite of the remonstrances of those who realized the danger of infection. Seven weeks after the birth of the baby Mrs. Dubois died.

Her sister, exhausted by the long strain, went back to Canada. She offered to take both children with her, trying to persuade Mr. Dubois and his mother that they would be much better off on a farm in Canada during the summer than in the hot, congested city. They would not let them go, however; and Miss Warren did what she could to insure good care for them. Her efforts were hampered by the fact that the family moved suddenly, leaving no address. By the time Miss Warren located them, Charles had been admitted to a hospital because of a severe *cold*. His eventual diagnosis was

tuberculosis in the glands at the root of the lung (a relatively mild form).

The doctors recommended outdoor treatment with good food; if this were secured, the outlook was not particularly grave, although no definite statement could be made as yet. Mr. Dubois was much distressed, and he and his mother listened attentively to Miss Warren's suggestions about caring for the little boy. After a conference with the social worker in the hospital where the child was, she explained to them that institutional care seemed advisable for him.

Unfortunately, however, all the available beds in hospitals open to patients with a Boston settlement were occupied. The State Hospital could not admit Charles because of his settlement, and none of the agencies caring for children would place him in a foster-home on account of his diagnosis, though the physicians were ready to allow it. It was felt that a country home, possibly one where the foster-mother was a nurse, though not so good as a sanatorium, would be much better than the child's own home. But even this was not to be had, and there was nothing to do but to send the child home, where he was supervised by a visiting nurse from the Out-Patient Department of the local sanatorium.

Meanwhile little Ruth was making slow progress. She gained a little in weight and seemed fairly vigorous and her father and grandmother were satisfied. Miss Warren was not, however, but neither she nor the social worker at the hospital where Charles had been, nor the visiting nurse, could move the family to take the child to the Baby Hygiene Station. As there were no definite evidences of physical neglect of the child, no legal steps could be taken.

Just before the baby was seven months old, she was taken suddenly ill and was sent to the hospital where her brother had been a patient. At first the diagnosis was bronchopneumonia, but this was changed within a few days to pulmonary tuberculosis. Ruth was sent at once to the City Sanatorium, where she died of miliary tuberculosis four days be-

fore she would have been a year old. Meanwhile Charles was getting on well at home, and when last heard from two years afterwards was in good health.

Mr. Dubois married again six months after the death of his wife, the marriage being an open secret until the year of mourning had expired. His second wife was a maid at the club where he worked and was in many ways a woman of the same fine type as the first wife. Her friends did all they could to persuade her not to marry Mr. Dubois; but she, too, was a victim of his winning personality and insisted upon having it her way and his. It was not long before it appeared that the burden borne so uncomplainingly by Elizabeth Dubois and which had fallen upon Grace Dubois was being accepted by her in the same manner.

Miss Warren was never able to get a penny paid on the bill of the Lying-In Hospital nor on that of the hospital which had treated the children. This was not, of course, her duty, but she felt it was the measure of her success in influencing Mr. Dubois. Wherefore, in summing up her work, she decided that she had failed completely in everything except the treatment of her original patient — which was, after all, the easiest part of the entire case.

COMMENT

On the medical side of the case, the progress of Mrs. Dubois's disease was entirely in conformity with the doctors' first prognosis; but their expectations with regard to the baby were not fulfilled. Why was she not saved? Little Ruth was not exposed to infection from the mother after birth; intra-uterine infection is not believed possible; and her brother was declared by the doctors to be a safe companion for her. She did not, to be sure, receive the best care possible; still, her progress was fairly steady until the onset of the illness which the winter brought her. The physicians who had known the case considered it an argument for intra-uterine infection — that is, for the possibility of such infection. In the case of Charles,

preventive work could have been done if there had been a responsive, helpful attitude on the part of the grandmother and father before he reached the hospital stage. Later the community failed in not making provision for him.

On the social side, the case causes one to wonder how much can be done in influencing an adult with faults like those of Mr. Dubois. To Miss Warren, his conduct seemed the outcome of the law of self-preservation, of unconscious adaptation to environment. A certain type of woman was necessary to his comfort and well-being, and he turned to her as a flower turns to the sun, knowing that without this source of strength he could not survive. Not a bad man in the usual sense of the word, his effect was nevertheless as baleful upon the women whose affections he held through appeal to their finest instincts. Possibly if his upbringing had been wiser, or if someone had attempted to eradicate his faults while he was still a child, results might have been obtained.

Someone will point out that the man was a psychiatric problem. This is true in the sense that all defects of character are psychiatric problems, though not to a degree that a well-trained social worker is not often able to treat them successfully. And a man like this, intelligent, but not sufficiently strong of will to be able to break up fixed habits and change his motives, is not, generally speaking, a person to be referred to the psychiatrists whose time is already more than filled with cases of far more urgency.

Another feature of the social treatment is the fact that while Elizabeth Dubois was kept in ignorance of her prognosis, her spiritual welfare was guarded according to the teaching of her faith. The priest entered willingly into the plan; she was saved anxiety and suffering; and since the knowledge of her impending separation from her children through death was not necessary in planning for their future, it seemed justifiable as well as merciful to withhold it.

It may be of interest to compare this case, first, with that of Mrs. Lourie, in relation to the problem of the children; and,

second, with that of Mrs. Young, where the clinical features are nearly the same.

E. W.

'Tuberculosis' is a word which like 'cancer' spreads a fear regardless of differences in the site and kind of disease, a fear often groundless but difficult to suppress. It is my impression that Charles Dubois (in Case 12) was as safe a child as any other to have in a household, quite incapable of infecting others. Unless this were so, the physicians in charge of his case would not have given permission for him to go to a foster-home, in case one could be found.

A change in names might be made whereby mistakes of this sort could be avoided. Some other term might be used for the slow, non-contagious, and often harmless infection of the deep glands in the chest, even though it is admitted that the disease in these glands is associated with the same bacilli which produce pulmonary tuberculosis.

R. C. C.

CASE 13

ELIZABETH YOUNG Age 37 *Married*

Admitted to ward January 25, 1922. Discharged February 12, 1922.

MEDICAL SOCIAL PROBLEM

Pulmonary tuberculosis with pregnancy; ample resources; illness of wife and mother.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Bilateral pulmonary tuberculosis with positive sputum; normal pregnancy of about three months. Therapeutic abortion and sterilization by ligation of both tubes.

b. *Prognosis:*
Is fair.

c. *Treatment:*
Patient to enter sanatorium as soon as possible.

d. *Further medical history secured by social worker:*
Patient has had prolonged exposure to pulmonary tuberculosis in mother and brother.

Social
(Family and patient)

a. *Analysis:*
Patient and husband are both native Americans; patient Anglo-Scotch stock, husband of English stock. They are members of Congregational Church. Husband is a native of Vermont. Patient was born in Pennsylvania. Since their marriage about thirteen years ago they have lived in a town in western Massachusetts. Their four children were born there. Husband owns a hardware store and makes comfortable income. They own their own home and have a good automobile. The health of husband and children is said to have been excellent always. Both patient and husband are well educated and cultured. Children are doing well in public school. Husband is kindly, sympathetic, affectionate; his first concern is his wife and children; he is a good business man; is deeply interested in his church whose precepts are his daily practice. Patient is optimistic and brave, sparkles

Medical
(Patient only)

Social
(Family and patient)

with animation and laughter, has a warm and generous nature, devoted to husband and children, but does not allow her own happiness to blind her to the misery of others; a truly noble and intelligent woman. Children are well-behaved, studious and clever.

b. *Treatment:*
   1. *Plan:* Arrange for sanatorium care for patient and examination of family.
   2. *Results:* Patient and son sent to sanatorium; others in family given examination and such treatment as needed. Two years later examination of brother arranged for.

c. *Sources of information:*
   Pastor.

2. Therapeutic Assets

Medical

a. *L.M.D.*: A good L.M.D. is available if patient returns home.
b. *Hospital care:* Will not be necessary after patient's recovery from operation.
c. *Nursing home:* Is not suitable.
d. *Convalescent home:* Is not suitable.
e. *District nurse:* Is not needed.

Social

a. *Family and patient:* Attitude of husband and children will be helpful. Patient's determination to get well and her general reactions are greatly in her favor. Home is an attractive comfortable nine-room house in residential neighborhood. Financial resources are sufficient.
b. *Relatives:* Patient's father, brother, and niece are in close touch with family, are sympathetic, intelligent, prosperous.
c. *Benevolent individual:* None needed.
d. *Private agencies and institutions:* Are available.
e. *Public agencies and institutions:* Public sanatorium is available.

NARRATIVE

A CLERGYMAN from the western part of the State who occasionally visited parishioners at the M.G.H., and whom Miss Carrington had been able to help now and then in arranging for convalescent care, change of work, or other essentials for his friends, came into the House Social Service Office one day, to speak to her of Mrs. Young, a member of his church, who was in a private room in one of the surgical wards. He did not know the nature of her ailment, but understood that it was not serious. Mrs. Young's home was so far from Boston that except for Mr. Young and himself she would have few visitors; and he asked Miss Carrington to go in to see her when she could. He spoke in the highest terms of both Mr. and Mrs. Young.

Before Miss Carrington called on Mrs. Young, she made herself acquainted with the medical history. The surgeon in charge of her said that Mrs. Young was in poor condition because of pulmonary tuberculosis, treatment for which was to be prescribed by the specialist who had sent her to the Hospital. Her stay in the M.G.H. would be determined by her recovery from the operation which had terminated pregnancy. From the record, Miss Carrington learned that Mrs. Young had entered the Hospital from the Consultation Clinic. This clinic is designed to assist physicians who wish specialists to examine their patients and make diagnoses, after which the patients return home for treatment or enter the wards of the M.G.H., if that is advised. The fees range from five dollars to twenty-five dollars, according to the amount of laboratory and X-ray work necessitated. Mrs. Young had been sent to this clinic to secure a decision as to possible extrauterine pregnancy. During the examination, the pulmonary trouble was found, and a therapeutic abortion followed by sterilization was recommended by the surgeon and physician, both of whom were specialists.

When Miss Carrington introduced herself to the patient,

she learned that the clergyman had already spoken of her. She found Mrs. Young a charming woman in every way and as brave as she was attractive. She understood her condition and was facing the future open-eyed and determined to get well. Although her mother had died of pulmonary tuberculosis, she was not afraid of the disease nor of its treatment; whatever the doctors recommended, she was ready to do. She was aware of the danger to her children if she were to go home; but she knew nothing of the substitutes for home care. Accordingly, Miss Carrington explained to her the nature of treatment at sanatoria, and enumerated the available State and county institutions in Massachusetts and the private places. When Mrs. Young asked her what *her* choice would be, Miss Carrington recommended the public sanatorium provided by the county in which Mrs. Young lived. The building was modern, of attractive design and construction, ideally located, admirably equipped, and had for Superintendent a physician of high standing. Miss Carrington reminded her, however, that the specialist in tuberculosis who had sent her from the Consultation Clinic to the ward would see her again later on, and would probably discuss the various possibilities with her.

From day to day, Miss Carrington dropped in to chat with Mrs. Young. She learned that she was not worried at all about home affairs, since a young orphaned cousin of her husband's was a member of the household, and was capable of managing that and of looking after the children and directing the servant. Further, her husband, whom she adored, brought her frequent reports that all was running smoothly. When Miss Carrington met Mr. Young, who was all that his wife and pastor thought him, she felt that Mrs. Young's confidence was well-founded.

Mr. Young was distressed by his wife's condition, but endeavored to conceal his anxiety. Miss Carrington had meantime talked with the specialist on tuberculosis about the case and had asked him what he thought of sending Mrs. Young to

her county sanatorium. He approved of the institution, thought highly of the Superintendent, and advised Mrs. Young to go ahead with whatever arrangements Miss Carrington recommended. The idea of sanatorium treatment frightened Mr. Young; but he finally became reconciled, and it was decided that his wife should go at the proper time.

He was still more uneasy when Miss Carrington spoke to him of having the children examined — the necessity of it startled him, and, as he wished to have them seen by a specialist, it involved the difficulty of getting the four from their distant home into Boston. He solved his own problem, however, when he suggested to Miss Carrington that she ask the Superintendent of the sanatorium, where their mother was going, to examine the children. The Superintendent consented and a day was fixed for the examination. Miss Carrington advised him to take morning and afternoon temperatures for three days before the examination and take the record with him. This might save an extra trip.

In due time, Mrs. Young was discharged. She made the journey to the sanatorium in her car, which was provided with every comfort; and Miss Carrington had seen that an excellent luncheon with hot beverages was prepared for her. Arriving in good condition, she settled down contentedly for a stay of at least a year. A week later, her eldest child, a boy of eleven, was admitted to the sanatorium, the examination having shown a rather mild infection at the apex of one lung which made it seem well for him to have treatment until the following autumn.

Four months later, Miss Carrington was in the vicinity of the sanatorium and drove over to see Mrs. Young. She found her immensely improved. Ralph, too, was benefiting by the treatment; and both were contented and happy. Miss Carrington did not need the Superintendent's assurance to be convinced that this mother and son were good for the other patients. No one could fail to feel better in one way or another because of a visit with these two.

Mrs. Young took advantage of the visit to ask advice about a young cousin whose health was not good. If she came to the M.G.H., would Miss Carrington see that the girl was not lost in the crowd? Miss Carrington was glad to reassure her as to this, and three weeks later, Edna Jewett, accompanied by the clergyman's wife, came to her office and was taken to the clinic. The chief difficulty was found to be poor hygiene including faulty posture. Equipped with instructions to better this, Miss Jewett returned home and got well.

Two years later, Miss Carrington had a letter from Mrs. Young asking her how her brother, Mr. Barrows, could be admitted to the Consultation Clinic. Mr. Barrows, who lived in Maine, was not well, and, as his physician was not sure of the diagnosis, he wished him to see a specialist. Having his sister's experience in mind, Mr. Barrows wished to go to the M.G.H. Miss Carrington sent Mrs. Young the necessary information and soon afterwards she came to the Hospital with her brother. The diagnosis in the Consultation Clinic was old healed tuberculosis. The physicians said there was no cause for alarm and no need of sanatorium treatment; he was told to return home to be under observation and treatment from his own doctor. Both Mr. Barrows and his sister heaved a sigh of relief, for they had feared he had cancer.

Miss Carrington was much pleased with Mrs. Young's condition. To be sure, the disease was still smouldering; but it was kept under control by her scrupulous attention to the orders of the sanatorium whence she had been discharged after a year's residence. She knew danger signals; and she kept in close contact with her physician. A woman of intelligence, she lived within the limits prescribed, finding and dispensing happiness within them.

COMMENT

The most important factor in this case is the intelligence of the patient and her husband. From this followed naturally the success of all the other measures advised; the sanatorium

treatment, the home arrangements, the plan of future life, the consideration of the health and welfare of others. It was a privilege to know this delightful couple. If the social worker is ever tempted to neglect follow-up work in the families of patients, such histories as this and that of Arturo Martini ought to make her realize that it is never safe to omit what seems, in the particular case under treatment, an entirely unnecessary procedure.

E. W.

CASE 14

PAUL DUVAL Age 20 *Single*

Admitted to ward October 2, 1919. Discharged October 16, 1919.

MEDICAL SOCIAL PROBLEM

Pulmonary tuberculosis; tuberculous colitis; paralysis of right leg due to old infantile paralysis. Very meagre financial resources; poor family spirit.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Pulmonary tuberculosis with positive sputum; tuberculous colitis; paralysis of the right leg due to old infantile paralysis.

b. *Prognosis:*
Very poor, as patient's whole system appears to be involved. Will probably live not more than a few months.

c. *Treatment:*
Patient needs sanatorium care as long as he lives.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient comes from French-Canadian stock; is a Roman Catholic. Family consisting of father, two sisters, and patient moved to New Hampshire from Canada about a year ago. They live on a farm which is quite isolated. Father is a laborer on near-by farms earning about $20 a week. Patient has done a little work in a local factory when health permitted. Sisters, aged 19 and 15, run farm and do housework. The father and sisters are said by patient to be in good health. None of the family appears to have much education. Patient speaks practically no English and poor French. He is anxious to enter into any plan for his benefit; feels sure of recovery; is self-reliant and considerate toward his family.

b. *Treatment:*
1. *Plan:* Get patient into a sanatorium in New Hampshire; remove from M.G.H. at once; notify father; if

Medical (Patient only)	*Social* (Family and patient)
	necessary, raise money to transport patient. 2. *Result:* Patient placed at his own expense in local sanatorium pending admission to New Hampshire sanatorium. Money raised for ticket to New Hampshire, as no notice was taken of patient by family in response to appeals. c. *Sources of information:* None.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: None available for treatment in patient's home town. b. *Hospitals:* Will not admit patient because of diagnosis. c. *Nursing homes:* Will not admit patient for same reason. d. *Convalescent homes:* Are not suitable. e. *District nurse:* Not available.	a. *Family and patient:* Family apparently unable and unwilling to do anything. Patient ready to do as advised. Home is an isolated New Hampshire farmhouse with five rooms, far from doctors, and with no district nurse or tuberculosis nurse available. b. No *relatives* to help. c. No *benevolent individual* interested. d. *Private agencies* will provide funds to remove patient to New Hampshire. e. *Public sanatorium* of New Hampshire is available without charge to patient. Massachusetts State Hospital will admit patient, but it is better to place him nearer home.

NARRATIVE

When the doctor in charge of Paul Duval asked his social worker, Miss Howard, to arrange at once for sanatorium care for the patient, she was already acquainted with the lad, having talked with him frequently as she made her daily round of the wards. From the first she had been sorry for him

because he was ill so far from home and had apparently no friends near, for no one visited him. There was something pathetic about his face in spite of (or perhaps because of?) his cheery certainty that he was going to get well as a result of his treatment at the Hospital.

Coming here had been a real adventure. For months he had hoarded every penny he could get hold of until finally he had sixty dollars, a sum that seemed to him adequate for any possible expenditure. His leg was to be helped and the uncomfortable feelings in his *stomach* were to be cured. Already he felt better because of the care he had received, and he was sure the sanatorium treatment advised by the doctors would result in great improvement.

Realizing that his disease could not be treated at the M.G.H., he committed himself to Miss Howard's hands. She explained why it would be necessary to move him to a local sanatorium pending his admission to the one in New Hampshire. He had been told before he was admitted to the M.G.H. that reduced rates or free care could not be given to patients coming from out of the State, although as much time as necessary was allowed in which to pay the bill. He insisted upon paying as much as he could before leaving.

The municipal sanatorium to which Miss Howard transferred him had so many vacancies at the time that it was willing to admit non-residents at ten dollars a week. She calculated that it might be necessary for Paul to remain a week. Therefore, he kept out twelve dollars, and though urged to wait with this until he returned to New Hampshire, paid the remainder to the M.G.H. on account.

The official who controlled admission to the New Hampshire sanatorium being absent, arrangements were delayed, and when at the end of a week Miss Howard was notified to send on the patient, two obstacles had arisen. In the first place, Paul was less able to stand the journey, and in the second, he had not enough money to pay for his ticket, his father having ignored his letters and one from Miss Howard. That

difficulty Miss Howard overcame by application to a local social agency which specializes in helping the sick; but the patient's condition troubled her greatly. Finally she succeeded in arranging for a nurse at the local sanatorium to accompany him, the same agency agreeing to pay her fare. The New Hampshire authorities were notified of the time of Paul's arrival.

When the day came, Paul was so exhilarated by the thought of returning to the vicinity of his home that the physicians felt it safe for him to make the one-and-a-half-hour journey alone, providing that the conductor of the train would keep an eye on him — a plan that relieved the sanatorium as it could ill spare a nurse for the trip. Miss Howard took the boy to the station in the Red Cross ambulance in order to conserve his slight strength. Then, having installed him in the car with a letter in his pocket giving his name and destination, and the knowledge of what he must do to avoid spreading contagion, she sought out the conductor. He readily agreed to look after Paul's comfort during the journey.

The boy went off gaily. The only thing that troubled him was his father's failure to write to him or to Miss Howard, but he found excuse for this. Having been notified of Paul's safe arrival and admission to the sanatorium, Miss Howard closed her record. From the boy himself she never heard again; but a year or so later, when she wrote to the Superintendent of the sanatorium asking for a report on the case, she learned that Paul had died in the sanatorium two months after his admission.

COMMENT

One of the serious problems confronting the social workers of the M.G.H. is that of the large number of patients from outside the State who come to the Hospital for diagnosis and treatment and are later referred to the Social Service Department by the physicians for arrangements for their transportation to their home State and perhaps for further treatment.

When there are absolutely no facilities near their homes, treatment must be carried on, if at all, in Massachusetts. These cases often present complicated problems, especially on the financial side. Sometimes the mere transportation is difficult to arrange. If the patient is clearly seriously ill, the railroads will not carry him without an escort; if he must travel on a stretcher, even for an ordinary fracture, he must be accompanied. It is obvious that no social service department can spare staff members for this escort duty as a regular thing; and it takes time and effort to find people who will act for them.

It is a matter for special acknowledgment that the railroad officials do everything in their power to make the journeys of these sick people as safe and comfortable as possible. Time after time, patients report on the friendly attentions of the train crew to whose care the social worker has commended them.

State officials in the neighboring communities are always ready to help. In this case, the New Hampshire authorities took over full responsibility for the examination of the patient's family and for treatment if necessary.

E. W.

The case being medically hopeless at the time of our first contact with the sufferer, the social worker's efforts could extend no farther than to get him at once out of a hospital, the rules of which did not allow him to remain there, and to have him properly cared for temporarily until a place was open for his permanent care and then to have him transported there as safely, comfortably, and cheaply as possible.

The heartless failure of his family to offer any help or even to write apparently did not discourage him and 'he went off gaily.' We hope that his last two months of life were sustained in the same spirit or something like it. At any rate, we did what we could to make the end of his life bearable.

R. C. C.

CASE 15

CATHERINE REILLY Age 17 *Single*

Admitted to Orthopedic Clinic November 18, 1922. Referred to Social Service department December 17, 1922.

MEDICAL-SOCIAL PROBLEM

Tuberculosis of hip; inadequate income with partial dependency on relatives; background includes anti-social behavior in father, possibly in mother, and low standards of home-making.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Tuberculosis of hip of twelve years' duration. There is considerable motion and flexion of hip.

b. *Prognosis:*
With corrective surgery there is a good prospect of patient's being much improved.

c. *Treatment:*
Correction of hip position by operation advised.

d. *Additional medical history secured by social worker:*
Prolonged exposure to pulmonary tuberculosis.

Social
(Family and patient)

a. *Analysis:*
Father and mother of Irish extraction; Roman Catholics; children born in Massachusetts. Father died of pulmonary tuberculosis when patient was two years old. One sister and one brother died apparently of same disease. Father was a heavy drinker, so family suffered many privations; public and private aid necessary over a period of years. Rent given free by relatives. Only regular income is $10 a week earned by patient. Legal settlement in Boston. Mother needs surgical treatment for varicose ulcers on leg. Brother and sister apparently well. Fair degree of education in all members of the family. Brother has no trade; works at anything he can get. Father was said to have been an excellent workman at his trade, but could not keep jobs because of his intemperance. He was fond of his wife and children and worried greatly about them while he was ill, but apparently

Medical
(Patient only)

Social
(Family and patient)

not to the point of guarding them against his disease. Mother was said to share father's intemperance at one time, but this is not proved, nor is there proof of immoral conduct suspected after father's death. She was a poor housekeeper, but improved until at last home was well cared for. Grateful for help given; self-respecting attitude toward it. Married sister Agnes showed delinquent tendencies as a girl. Brother Charles, aged twenty-three, inclined to drift; does not work steadily. Patient was in an institution for care of crippled children from age of four to that of twelve. Received a fairly good education there, but practically none since discharge. Has worked in stock room of a clothing factory at a job which leads nowhere. Is good at figures, always ready and eager to help at such work. Has real sense of responsibility toward mother. Is a little inclined to be headstrong and sometimes needs prodding to keep on the job, but has a good voice and is bright enough to make something of herself if encouraged. Appreciative of interest and help.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Not needed.
b. *Hospitals:* M.G.H. Orthopedic Ward for operation is available free, if necessary.
c. *Nursing homes:* Are too expensive.
d. *Convalescent homes:* Not suitable, as too much activity is required.

Social

a. *Family and patient:* Mother will give good care, but will not be able to stand much physical strain. Patient's courage and sweet nature will help a great deal. No assistance is to be expected from sister. Excellent home conditions.

Medical

e. *District nurse:* May be necessary at first to show mother how to care for patient, but need not go in often.

Social

b. *Relatives:* Maternal uncle and cousin are able and willing to continue to aid financially and in every other way.

c. No *benevolent individual* is interested.

d. *Private agencies and institutions:* Will give or lend the price of apparatus.

e. *Public agencies and institutions:* The State Department of Education, Division of Vocational Guidance, will train patient for another type of work.

NARRATIVE

Catherine Reilly, a brown-haired, dark-eyed girl, with a frank, straightforward manner, steady, level gaze, and a chin square enough to make the observer feel that she would stick to her proposed line of action, came to the Orthopedic Clinic one day with the word that she needed a new high-soled boot and had been advised by an institution for crippled children, where she had spent eight years, to come to the M.G.H. When she was examined by one of the physicians, however, she was advised to have an operation. She was then referred to the social worker for arrangements.

The girl appeared before the social worker greatly upset by this wholly unexpected advice. It came out, however, that she wasn't afraid of the operation, but was distressed at the thought of her mother, who would have no means of support if Catherine stopped working. The social worker told her she was sure some way could be found for caring for her mother and asked the girl to bring in some of her family to talk with the doctor. Catherine said that her father was dead and her mother had something wrong with her legs which made walking almost impossible; but she thought her mother's cousin, Mrs. Lynch, would be glad to act for her.

A few days later, Mrs. Lynch came into the clinic and told

Miss Moore something of the family history. Mr. Reilly and two children had died of tuberculosis; Mrs. Reilly had some chronic trouble in her legs; and Charles, the son, worked only at odd jobs and could not be depended on to contribute to the family income. Mrs. Lynch gave them their home free; she lived upstairs and they downstairs; and other relatives gave food and clothes as they were able. Mrs. Lynch was deeply interested in Catherine and was ready to do what she could to help. She could aid in the care of Catherine after her discharge from the Hospital and she and Mrs. Reilly's married brother could cover the family expenses; but they would not be able to pay the Hospital bills. The latter, however, was the least of the difficulties, and Miss Moore assured her that if necessary the Hospital would furnish treatment free.

From various social agencies that had known the family for over fourteen years, Miss Moore gained additional facts. Mr. Reilly had been a capable worker at his trade, but had been a drunkard and relatives had always had to aid the family. When he fell ill, the Tuberculosis Association enlisted the help of a relief agency which made it possible to keep the family together. Sanatorium care for him was not available because his condition was hopeless, and as he objected to going to a hospital for incurable cases, the family was exposed to contagion for several years. Finally he entered a public hospital for chronic cases, where he died. Mrs. Reilly and the children then found a home with her father. There were rumors of drinking and immoral conduct on the part of Mrs. Reilly which were not verified; and there was a question about the character of one of the daughters. There was no question, however, about the health of the family which gave the agencies concerned considerable trouble. Mrs. Reilly, moreover, thought that she was the one that was troubled; doctors and nurses were forever 'bothering' her and she retaliated by hampering them whenever she could. When Catherine was four, her need for treatment for tuberculosis of the hip was met successfully; but two of the other children fell victims to pulmonary tuberculosis.

All the records — those of the Settlement House, the Family Welfare Society, the district nurse, and various medical-social agencies — reported Mrs. Reilly to be the poorest of housekeepers. But when Miss Moore visited the family, eight years after the withdrawal of the other agencies, she found an entire change in that respect. The home, consisting of kitchen, dining-room, living-room, two bedrooms, and bathroom, well furnished and heated with steam, was immaculate. Of course Mrs. Lynch's generosity had made the home possible, and possibly she had helped to raise the standards, although her own home was open to improvement. It was easier for Mrs. Reilly to keep things orderly and tidy and to take an interest in doing so with the drunken husband and father removed from the scene. Nevertheless, Miss Moore believed that the unwelcome social workers and nurses, who had gone in and out doing all they were allowed to do, had had their influence in bettering things; the institution where Catherine had spent eight years and whose teachings she must have brought back to share with the family had undoubtedly been another source of improved standards.

Once Catherine was in the ward, Miss Moore began to plan for treatment for Mrs. Reilly. She was examined in the Surgical Clinic and operative treatment for the varicose veins in her legs recommended. After much persuasion, she finally agreed to come in to the Hospital for an operation as soon as Catherine should be sufficiently recovered from her operation to be able to get about at home.

Catherine's former employer gave so good a report of her that it seemed she should be prepared for more responsible work along the lines of her aptitude. Accordingly, while she was still in the ward, Miss Moore enlisted the aid of the Vocational Division of the State Department of Education, and Catherine's convalescence was put to a profitable use by a course of reading which lead toward training in filing and bookkeeping.

Charles, the other member of the family living at home, also

came in for attention. Miss Moore did not, it is true, succeed in getting him in to the Out-Patient Department to have him examined for a mysterious weakness in his back; but under the influence of her friendly interest, he found himself a job at fourteen dollars a week, which more than made up for the lack of Catherine's wages. Thanks to this, Mrs. Reilly found herself able to pay the eighteen dollars, which was half the expense of Catherine's brace, the remainder of the sum being paid from a special fund at the Hospital. She paid a dollar a week regularly without reminder from Miss Moore.

Catherine returned home and got along well. Finally Mrs. Reilly entered the ward for her operation. She was in the Hospital two weeks and got excellent results from the treatment. Although Catherine had had free treatment, she felt that she could pay $10.50 a week for herself if given time. She paid the bill gradually, sending Miss Moore a dollar at a time.

Within six months of her operation, Catherine was at work on a new job earning eleven dollars a week. Charles was now making nineteen dollars a week, so the family income was sufficient for their comfort. Miss Moore followed Catherine for another period of eight or nine months, and then, as everything was going on well, withdrew.

COMMENT

This case shows the effect of social work ten years before a hospital-social worker entered the case. Part of the marked improvement in Mrs. Reilly and in the home may be attributed in all probability to social workers as well as to the influence of Mrs. Lynch. Without going into it here, what may be called 'internal evidence' (in a special sense) shows this. To be sure, there was another factor — the death of Mr. Reilly.

It is frequently noticed that the removal of the dominating personality in a family group sets free qualities latent in the others. Often astonishing improvement in both physical and spiritual matters results. There are indications that this was

the case with Mrs. Reilly. In the matter of Catherine's influence upon the home, it must be considered that she was in a peculiar sense the product of medical-social work. Hence, what she may have taught the mother directly or indirectly is only one remove from what the social workers themselves inculcated in Mrs. Reilly.

E. W.

The case also illustrates a point which is clear in many other cases of this series as well — the beneficent effect of the medical-social worker's tendency to extend her hygienic and friendly interest beyond the ills of the patient who happens to think of coming to the hospital. Other members of the family are drawn into the field of medical care. The family as a whole is ultimately benefited. This is all the more important because hospital physicians and private physicians alike tend to ignore the patient's family and attempt to deal with him as an independent unit, mainly because he is in sight and his family out of sight.

R. C. C.

CASE 16

ROSE GORE Age 13 *Single*

Admitted May 3, 1920; discharged May 24, 1920.

MEDICAL SOCIAL PROBLEM

Tuberculous peritonitis. Ignorance of parents leading to conflict of medical advice; material prosperity without cultural background, leading to false standards.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Tuberculous peritonitis. On admission there was fluid at both bases and considerable ascitis. X-ray of chest showed no definite evidence of pathological process in lung fields and no evidence of fluid. Five months ago patient was tapped for tuberculous pleurisy by L.M.D.; two quarts of fluid removed. In view of both history and X-ray findings doctors believe fluid at bases is due to upward displacement from abdomen.

b. *Prognosis:*
Prognosis is fair with long rest in bed.

c. *Treatment:*
Patient should go to a sanatorium.

d. *Additional medical history secured by social worker:*
None obtained.

Social
(Family and patient)

a. *Analysis:*
Parents are Jews born in Russia. Father came to United States eight years before family. Father is a successful business man with ample resources. He is an American citizen and has a State settlement, but not a local one. Health of the family is good. Father has considerable education, but no real culture. Mother has very little education. Two children besides patient are doing well in public schools. Father owns a mercantile establishment of considerable size. He is talkative and opinionated and is weak in parental discipline; thinks his word is law, but is ruled by wife and children through his emotions. Is sufficiently intelligent to grasp medical situation, but has no real power of reasoning. Mother seems to have no will of her own. Is retiring in manner except in own home — there asserts herself. Has adapted herself to American customs very readily. Is fond of display in dress. Both parents think

Medical (Patient only)	*Social* (Family and patient)
	money enables one to do anything and everything. Patient's sister and brother seem to be well-conducted children, but nothing definite is known. Patient is a clever child in sixth grade; is somewhat spoiled and inclined to get her own way with father by crying; is ambitious, responsive, and sweet-tempered.
	b. *Treatment:* Need of sanatorium treatment explained in detail. Attempt made to give a more just appreciation of values. Persuasion to follow doctor's advice apparently successfully applied, but ultimate failure occurred.
	c. *Sources of information:* No outside sources.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Doctors of very high order are available.	**a.** *Family and patient:* Intelligent cooperation of parents cannot be counted on. Patient has a far better attitude toward her need of treatment, but is too young to assert herself enough. Excellent home.
b. *Hospitals:* Sanatorium care of the best can be obtained.	b. *Relatives:* Are prosperous, but are of same semi-educated type.
c. *Nursing homes:* Are not suitable because of diagnosis.	c. *Benevolent individual:* None.
d. *Convalescent homes:* Not suitable.	d. *Private agencies and institutions:* No occasion for them.
e. *District nurse:* Not available and probably not acceptable to family anyway.	e. *Public agencies and institutions:* Not available.

NARRATIVE

I was in the ward when Rose was admitted accompanied by her parents, and my attention was at once drawn to them because of their very expensive clothes and the number of dia-

monds worn by father and mother. Noticing that the Head Nurse was not in the ward at the moment and that there was an evident feeling of constraint on the part of the family, I spoke a friendly word and drew up some chairs; while we waited for the Head Nurse I learned that it was Rose who had come for treatment and in general what her trouble was. The parents knew only vaguely what ailed her and had no idea of what the study and treatment of the condition might involve.

The friendly contact thus made was followed up by me. From day to day as the father and mother visited Rose, I made a point of seeing them for a moment, and with Rose I had long talks every morning on my rounds. She was lonely and shed tears frequently, but on the whole she was plucky. I was astonished to learn that she had been in this country less than a year. Only six months before she had arrived in New York with her mother, sister, and brother to rejoin the father who had been in America for eight years. The trip had been a long one from their old home, in what had been Russia before the war, but since then was Poland. They had spent three weeks in Paris waiting for a steamer — three wonderful weeks! Rose told me of all she had seen there and told me correctly too; even now she remembered it so clearly that she was interested to hear more of the history associated with the scenes she had visited. She drew analogies between the French Revolution and the Russian one through which she had lived. She even saw some of the similarities in the modern art of the two countries.

It was not hard to understand why this child, knowing no English on her arrival in Boston, had entered the sixth grade in the public school and held her own there. The conviction grew on me that if I could only convince her of the wisdom of the plan of treatment that might be recommended the day was won, for she would rule her parents. So I put it before her as if she were really of an age to decide for herself. Gradually she was persuaded that several months in a sanatorium as recommended by the doctors would not be a calamity even if

it did postpone by one year her graduation from high school. Her eagerness to get through school was due to the family plan of all working in the business as soon as possible. Rose was to be the bookkeeper and she found the prospect highly alluring.

When I talked with Mr. and Mrs. Gore about sending Rose to a sanatorium, as advised by the doctors, I was told that expense was no obstacle, as Mr. Gore had been very successful in business and could afford anything necessary. (They were naïvely unaware that they were too prosperous for the wards of a hospital.) The charge of twenty-five dollars a week at a sanatorium which I recommended was entirely satisfactory. The difficulty lay in convincing the parents that Rose, who was visibly improving, really needed to go away from home, for they had forgotten her steady decline at home during the six months before admission. Finally the doctor and I got their consent, and I sent in the application to the sanatorium. The date for Rose's discharge was set and all arrangements were concluded for her to go directly from our hospital to the sanatorium when Mr. Gore announced that he intended to take Rose home for over Sunday and an ensuing holiday and then take her to the sanatorium some five days later than at first planned. He said Rose and her mother were giving him no peace, as they had their hearts set on this plan. How could a man resist the tears of his family? No persuasion by me could move him and he was absolutely unable to grasp the doctors' objections, but he readily promised to put Rose to bed at home and in every respect carry out the doctors' orders. To make sure of holding the bed for Rose, he would at once pay in advance the first week's bill at the sanatorium. The doctors very reluctantly consented to the plan, which they admitted was not dangerous, only inadvisable. Rose, of course, was delighted to go home, even for so short a period. Her parents urged me to come to visit her there so that I could see for myself their very superior home; so I promised to come.

In accordance with the doctor's instructions I ordered the

ambulance to take Rose home, but did not remain in the Hospital to actually see her leave. Next morning the doctors told me that Rose had gone home (with all her clothes on) in a taxi. Mrs. Gore's tears at the idea of the ambulance, 'so like a hearse,' had proved too much for Mr. Gore. The doctors were convinced that no sanatorium would ever have the chance to welcome Rose. I was beginning to fear this myself.

Two days later, I visited the family, whose home was a seven-room apartment in a very good residential district. The rooms were lavishly and expensively furnished, probably by an interior decorator from a department store. Everything was immaculately clean and orderly and the impression was distinctly pleasing; but there were a few things indicative of a peasant background. Even with the ultra-modern American furniture one could see the influence of Russian Jewry. To the family their home was clearly palatial; no wonder they wanted me to see it and be properly impressed.

I found Rose lying on a lounge fully dressed. She had evidently been sitting at a window, however, for she naïvely said that when she saw me coming up the street she telephoned her father to come home at once to see me. Mrs. Gore and Rose were most cordial and showed me all over the home. In the kitchen the other children were playing cards. They were neither as good-looking nor as obviously intelligent as Rose, but still nice children. Mrs. Gore, dressed in a pathetic mixture of new American and faded Old-World clothing, her hair drawn tightly back and coiled in a knot on the back of her head, but with her diamonds around her throat and in her ears, presented a very different picture from the one she had made at the M.G.H. There she had always worn the most modern and expensive clothing, her hair had been elaborately dressed, and no one could have supposed her to be a recent immigrant.

While waiting for Mr. Gore, Rose and her mother entertained me, mainly by music on the new player piano which had been her father's present to Rose on her arrival home from

the Hospital. The sight of Mrs. Gore, so palpably alien to her surroundings, pedalling forth the newest musical atrocity for my delectation, was one I could never forget. The earnestness, the pride, the dignity, above all the friendliness, were most appealing; when one remembered what this woman had been through before she reached this home she seemed to typify the history of thousands of immigrants who struggle toward us eager to learn our ways — if only they can have an object lesson. Whose fault is it if they have no chance to see our best as well as our worst characteristics?

Finally Mr. Gore dashed up to the house in a very expensive automobile; he, too, was cordiality itself with many assurances of faith in the M.G.H. doctors. But — he told me that he had called in others who told him that Rose was not at all in need of sanatorium treatment and he could safely keep her at home. Whom was he to believe? He could not decide, so he had determined to make a test for himself. Rose was to stay at home, until, and if, she grew worse; then he would let me send her to a sanatorium. In the meantime he would have a certain very able physician supervise her; the physician he named was the same one who had tapped Rose for tuberculous pleurisy five months before. I was distressed, because I could see that already Rose was not obeying orders. I reminded him of his promise to keep her in bed. 'True, but when the child is well, why make her weak by staying in bed, especially as she cries all the time?' We talked for about two hours, but it was a losing game for me and, I feared, for poor little Rose too. She had no real chance with her parents so ignorant of what was for her good. The very financial success of which they were so proud was giving them false standards; they valued the medical opinion of a man who saw the patient once and charged forty-five dollars, more highly than that of the unpaid doctors in the Hospital who had seen Rose every day and all day long. Once more I saw the dangers of material prosperity to persons without any cultural basis for it.

At last I told Mr. Gore that he must, of course, make his

own choice, but that if he elected to ignore the Hospital's advice I could not help him do it. I explained very carefully how medical-social work rests on the most complete understanding and coöperation of the doctors and social workers; that as a member of the M.G.H. staff I could not work with a patient who was having medical advice with which the Hospital doctors did not agree. Nor could we allow a sanatorium application, which gave medical data for which we vouched, to be held in abeyance and perhaps be used when the medical situation had changed; therefore, I must withdraw the sanatorium application. Mr. Gore protested against this, as he wanted to use it later on if necessary, but finally he understood why the doctors actually in touch with the patient must be the ones to send information to the sanatorium. We parted on very good terms; I was thanked for coming to see them and was promised a report later on Rose's condition.

After notifying the sanatorium of what had occurred, I closed my record. Nothing has ever been heard from the family, from which I conclude that matters did not go well with Rose. Our experience is that no one likes to own up that he was in the wrong, but when his course is justified by events, he gladly reports it.

COMMENT

To many Americans, foreign-born as well as native (which leads one to infer that the trait is not a monopoly of the United States), the measure of an article's worth is its cost in dollars and cents. Always a dangerous principle, it is nowhere more so than in a situation like the one in the Gore family. And perhaps it is more serious in America than in many of the European countries because here there are so many persons who have accumulated wealth of a material nature while still in the direst intellectual and spiritual poverty. What this often leads to is shown by this history, not by any means unique in the files. But not always is the social worker obliged to sever her connection with the case; had she had an oppor-

tunity here to continue her work in coöperation with some physician who was in agreement with the M.G.H. physicians, it might have been possible in time to overcome the subtle forces which were at work to the disadvantage of the patient.

This case is a failure, none the less disappointing because the causes of the failure, which are obvious, were perhaps not wholly to be avoided.

E. W.

I am not at all sure that Rose did not get well at home. At any rate, the assumption that she died and the failure to look up the facts before concluding that the family and their doctor guessed wrong is not in my judgment justified. The treatment of tuberculous peritonitis, either in a sanatorium or at home, is largely guesswork. We have no real knowledge of the reasons why some patients get well and others die. Certainly the homesickness and uneasiness of Jewish patients in a sanatorium, especially if its dietetic rules are not in accord with their religion, often seem to undo any good effects of sanatorium hygiene. There is no medicine or surgery included in the management of such a case in a State institution. It is wholly a matter of rest, food, and air. Under these conditions I am by no means sure that the family decided wrong.

R. C. C.

CASE 17

HARRIET CARLETON Age 17 *Single*

Admitted to ward October 9, 1922. Discharged October 28, 1922.

MEDICAL SOCIAL PROBLEM

Tuberculous pleurisy with effusion; old trachoma in a young alien whose illness makes her deportable.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Tuberculous pleurisy with effusion; old trachoma in both eyes.

b. *Prognosis:*
Excellent if patient has sanatorium care where eyes can have proper attention.

c. *Treatment:*
Sanatorium care for six months at least. Further use of copper sulphate for eyes.

d. *Additional medical history secured by social worker:*
Patient contracted trachoma from mother.

Social
(Family and patient)

a. *Analysis:*
Parents are Canadians of English stock; members of Church of England. Family consists of parents, two sons, and two daughters including patient. They have lived always in a small village in Canada just across the border from a good-sized town in Vermont. They visited back and forth across the border in absolute disregard of any artificial barrier. Have never been in comfortable financial circumstances; therefore when a friend in Vermont who was moving to Massachusetts offered to take patient with her that she might have her eyes treated in Boston, the offer was gladly accepted. Patient has a fair education, writes very good letters both as to subject-matter and handwriting. She is brave, optimistic, self-reliant, with a good attitude relative to deportation; turns everything to good account. No data on family.

b. *Treatment:*
1. *Plan:* Carry out doctors' recommendations; notify fam-

Medical
(Patient only)

Social
(Family and patient)

ily; write public authorities in Canada in hope of bringing about medical treatment of mother and examination of family; keep in touch with patient until her deportation.

2. *Result:* Patient sent to the Sanatorium Department of the State Hospital with great benefit. Matters put in train for medical treatment for patient's family. Patient deported when in condition to stand the trip. She found employment in her native land where she continued under observation while at work.

c. *Sources of information:*
The hospital where patient's eyes had been treated prior to her admission to M.G.H.; friend who brought patient to Massachusetts.

2. Therapeutic Assets

Medical

a. *L.M.D.:* L.M.D. in home town will supervise her after she gets back and will treat family.
b. *Public hospital:* Is available in Massachusetts, but there is none in vicinity of patient's home.
c. *Nursing homes:* Will not admit patient.
d. *Convalescent homes:* Will not take patient.
e. *District nurse:* Is not needed.

Social

a. *Family and patient:* Family can do nothing beyond writing encouraging letters to patient. Latter's attitude is a valuable asset. Home is an eight-room house in a primitive community and is not suitable substitute for an institution in caring for patient.
b. *Relatives:* There are no relatives to help.
c. *Benevolent individual:* The family friend who brought patient to Boston can give her a home, but no financial aid.
d. *Private agencies and institutions:* None available.
e. *Public agencies and institutions:* Are available, but their use involves deportation of patient.

NARRATIVE

The Head Nurse having telephoned to say that a patient was in tears and the distracted House Officer had prescribed social service, Miss Carrington hastened into the ward to find Harriet Carleton weeping over the bad news she had just heard from the doctor. At her best, the girl was not good-looking. Her skin was freckled, her features indifferent, and her abundant hair was coarse and of an unattractive shade of red. But one had only to mark the firm jaw and to look into the steady greenish eyes to suspect that she was one to be depended on, that she would come up bravely if not smilingly after every encounter with rude fate.

A few words sufficed to put Miss Carrington in possession of the pertinent facts. Tuberculosis, sanatorium care, a seventeen-year-old girl, a foreign country, poverty — these were the pieces of the puzzle Harriet was trying to put together to make a picture of regained health. Happily, she was a sensible girl with ears to hear as well as eyes to weep; so she listened, sniffed a little, smiled, and agreed to do exactly as Miss Carrington advised. The plan was the simpler for certain factors which eliminated any choice. Sanatorium care must be provided; and as an alien without money, Harriet was eligible for this at the expense of the State of Massachusetts in its large free hospital out in the country. Of course this meant eventual deportation, but not until the patient could travel safely. In short, she could have her treatment free and be sent home at Uncle Sam's expense.

Her eyes still needed occasional treatment which would be provided in the same hospital. Moreover, as she said her mother had the same disease and had never had treatment, Miss Carrington purposed writing to the Ministry of Public Health in Canada and trying to arrange for treatment for her. She would also write to the doctor who had been kind to her and who lived in the Vermont town across the border from Harriet's home and ask for his friendly interest. Then she

would write to Harriet's parents, explaining what was happening, and assuring them that Harriet's social worker would stand by her as long as she remained in the United States. Finally, after Miss Carrington had had an interview with the friend whom Harriet was visiting in a city near Boston, the girl would be ready to go to the State Hospital where she would find waiting for her a social worker to whom Miss Carrington would give her a letter.

All went accordingly. Harriet set out in good spirits with a supply of note-paper and stamped envelopes to write to her family and her social worker. The latter sent several friendly letters to the girl during the five months she remained in the sanatorium. At the end of that period, she was in excellent condition and the United States Government sent her back to Canada, happy as a lark to be going home and to have regained her health. Once at home, she found work in a hospital where she would be under observation while at work. The Canadian Ministry of Public Health arranged for treatment for Mrs. Carleton's eyes. Although Miss Carrington never heard, she trusts that all went well with them thereafter.

All this benefit to Harriet resulted from the kindly act of her neighbor, who ignored an international border in her determination to get expert medical treatment for an ailing young girl. It makes one glad to be alive and at a social worker's post!

COMMENT

One frequently hears that the United States is less kindly in its treatment of aliens than its more humane citizens would wish. To anyone who understands the actual procedure of those who are charged with the administration of the laws pertaining to aliens, however, it is apparent that human understanding and sympathy modify the severity of the statutes. It appears to many social workers that complaints arise chiefly from the least intelligent patients. Men and women, and even adolescents, who are sensible and intelligent,

generally appreciate the necessity for these laws and are grateful for the benefits which they enjoy under them.

Moreover, many of the difficulties which arise in connection with the deportation of aliens may be attributed to ignorance on the part of social workers as well as of the patient and his friends. It is imperative that the social worker be conversant with the legal rights of her patient, lest she take such false steps as trying to secure admission to institutions to which he is not eligible, with the result of giving him and his friends the uncomfortable feeling of being shut out. If she knows what to do, she can act promptly, explaining that there is but one possible course of action. This is far kinder toward the patient; for it is as true to-day as ever it was that 'hope deferred maketh the heart sick.'

E. W.

CASE 18

GERTRUDE SMITH Age 41 *Single*

Admitted January 12, 1908; discharged February 23, 1908. Admitted December 30, 1909; discharged February 6, 1910.

MEDICAL SOCIAL PROBLEM

Renal tuberculosis with involvement of the bladder; long-time sanatorium care for patient without money or relatives.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Renal tuberculosis with involvement of the bladder; right nephrectomy nine years ago.

b. *Prognosis:*
Poor, but patient may live and be able to work for some time if treatment is successful.

c. *Treatment:*
Patient needs sanatorium care for a period of months; if this cannot be secured and she must work, then she should have as much rest, fresh air, and excellent food as possible.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Parents were natives of the United States. Died when patient, their only surviving child, was thirteen years old. Nothing positive is known about them, but patient cherishes their memory. Patient is a native of Massachusetts. Has been on her own resources since parents died. Was treated coldly by relatives, but found kind employers who treated her as a member of family while she was growing up. Her employers gave her a year's vacation on a farm following the operation for removal of kidney. Has no local settlement, as she has lived in many places, but has a State settlement. Health was never very good; has been uncertain since 1907; failing for past six months. Went through grammar school; has better command of spoken than of written English; considerable degree of refinement acquired from employers. Began as nursemaid in a country home when thirteen years old; gradu-

Medical
(Patient only)

Social
(Family and patient)

ally worked up to position as companion to an old couple with whom she was still living when operation was performed. Since the year's rest she has done clerical work in various small hotels. For past four years has been with an inn in a small town where work is light and living conditions good. Has excellent reputation. Is brave, cheerful, faithful to friends and employers; intelligent.

b. *Treatment:*
   1. *Plan:* Carry out doctor's orders for sanatorium care.
   2. *Results:* Sanatorium care arranged at public expense. Supervision given for sixteen months during which contact was maintained mainly through letters which were sent about once a fortnight at first, while patient was in sanatorium. After patient left sanatorium, assistance given in obtaining temporary work until she could return to the inn, which took her back when vacancy occurred.

c. *Sources of information:*
   Friends; employers; L.M.D.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Could supervise in community, but with difficulty, as patient lives at long distance from him.

b. *Hospitals:* State sanatoria are available only for pulmonary and laryngeal cases and local ones upon payment of non-resident rates.

c. *Nursing homes:* Patient excluded by diagnosis and by finances.

Social

a. *Family and patient:* Patient is without family; she has about $100 saved. Her optimism, courage, reasonableness, confidence in L.M.D. will assist in treatment.

b. *Relatives:* Relatives who cast her adrift could help, but patient will not permit them to be approached.

c. *Benevolent individuals:* The employers who befriended her in 1908 have since died.

Medical	*Social*
d. *Convalescent homes:* Cannot give suitable treatment.	d. *Private agencies and institutions:* None are available.
e. *District nurse:* Not needed.	e. *Public agencies and institutions:* Sanatorium Department of the State Almshouse Hospital will admit patient, but this is not advisable because of psychological effect on patient. County Sanatorium will admit patient, but at expensive rate.

NARRATIVE

One day in 1919, a surgeon on the M.G.H. staff telephoned from his office to consult the Chief of Social Service about a private patient who was there at the time. He outlined the medical situation and said he needed some one to look out for the social aspects of the case. Since the patient had been operated upon at the Hospital ten years earlier, he was asked to send her to the office to talk with a social worker. Accordingly Miss Smith appeared, bringing a letter from the surgeon which repeated the medical data. Miss Carrington, one of the staff workers, talked with her at length and obtained the social history upon which to base her activity. She made it clear to Miss Smith that the laws governing the admission of patients to the sanatoria were such as to involve difficulty and delay and asked her to wait at the home of her friends until plans could be made for her. If medical treatment were needed meantime, she could visit the surgeon; but this seemed unlikely, as she had his advice whereby to govern herself.

Miss Carrington then talked with the surgeon in regard to the patient. Further operative treatment, he said, was out of the question; and the utmost that could be expected was postponement of the end; but he thought that if Miss Smith were sent to a sanatorium she would probably so improve as to be able to return to work for a year or more before permanent care would have to be provided. And he believed this relief to her was well worth any effort; the patient had fought pluckily

for years, and he had been glad to do all he could for her. If the money had to be raised privately, he wished to contribute.

Miss Carrington visited Miss Smith, who was staying with friends in a comfortably furnished apartment in a pleasant residential district of a town near Boston. Her friends were kind and considerate, though they were secretly uneasy lest there be danger of infection for themselves. Reassured as to this, they declared that Miss Smith was more than welcome to remain with them until she could be admitted to a sanatorium.

At this time, Gertrude Smith was forty-one years old. At thirteen she had been left an orphan without money, but with relatives in comfortable circumstances. They reluctantly took charge of her for the time being and began at once to try to rid themselves of the burden of her support by getting her apprenticed to some industry on a small scale where she might live with the family of the foreman. Their efforts were unsuccessful and shortly afterwards they let the girl know that she was old enough to earn her own bread and that they were unwilling to keep her. So the inexperienced child of fourteen struck out for herself and found a place as nursemaid in a pleasant home in the country. She was kindly treated and left this place only because she needed more money than the family could pay. After that she worked for several families, finally getting a place as companion to an old couple and living with them for a number of years. She was with them, when, just before she was thirty, she developed renal tuberculosis and was operated upon at the M.G.H. Following the operation, her employers sent her to a farm in Vermont, paying her expenses for a year. Greatly benefited by this, when she was able to work she was helped to secure a clerical position in a small hotel where conditions were favorable to her. Since then she had kept to this line of work, going from one town to another as openings occurred, until she found her present job which was an improvement over the others in being steady where they had been seasonal. Here she spent

four happy years, when the recurrence of symptoms similar to those of ten years before brought her back to consult the surgeon, whom she had not seen for some time. Her chief difficulty now was her lack of money, for she had only about one hundred dollars. She explained that she had never received more than twenty-five dollars a month with maintenance, and since, in accordance with the doctor's instructions, she had taken good care of herself, she had been unable to save. She said that if she must, she would go to the Almshouse Hospital, but it would be only to die; she could never get well there.

Though Miss Smith felt ill, she refused to see the surgeon again, saying that she had already taken so much of his time that she did not feel it right to trouble him further. Miss Carrington, however, knew the man so well that she convinced Miss Smith that he would be hurt if he knew she did not consult him because she could not pay for his services. She therefore visited him once or twice during the month while she waited. Having decided upon a sanatorium, Miss Carrington found that there was a vacancy and learned the price to be paid. The Superintendent told her that the State Board of Charity would have to apply through the local Board of Health before he could accept the patient. The former Board agreed to provide for the patient, but referred Miss Carrington to the Board of Health in the town where Miss Smith was staying. Application was made accordingly, and the Board was assured that it would be reimbursed by the State for the patient's expenses at the sanatorium. Unhappily, however, in spite of Miss Carrington's endeavors, she could not manage it so that the plan could be grasped by the local authorities. This was chiefly because the representative with whom she dealt, though a delightful old gentleman with an inexhaustible flow of anecdotes, was deaf and disliked doing business by correspondence. Back and forth Miss Carrington went, between the State House and the local town hall, with side trips to see the patient, the only result being

her own conviction that she must perfect her technique for dealing with the deaf. Finally the State advised sending Miss Smith to the sanatorium at her own expense until the question of reimbursement by the local Board could be settled. Miss Smith agreed to use her one hundred dollars, which would pay for eight weeks.

She entered the sanatorium one month after Miss Carrington had begun work on the problem. Her equipment was given her by her hostess, who also went with her to the sanatorium, which was about seventy-five miles from Boston. So far, so good! Now began the attempt to decide through whom the State would pay for Miss Smith's care. There was no doubt that the State would pay; but the local authorities were reluctant to become the intermediary. Finally, after interviews, correspondence, and numerous telephone messages, it was decided that the Overseers of Public Welfare in the town where the sanatorium was located should assume the responsibility of acting as paymaster for the State Board of Charity. Four months and a half after Miss Smith entered the sanatorium, the Superintendent was officially notified by the State that the bill would be paid by the local Board of Health.

Miss Smith, who was in bed almost constantly, improved slowly but steadily. Miss Carrington had four other patients in the sanatorium and she asked them to help make Miss Smith feel at home. Cards and letters were sent her irregularly, but at frequent intervals, reminding her that she was being kept in thought and encouraging her to expect restoration to a considerable degree of health. After she had been there nearly six months, she was allowed to try what the effect of a little work in the sanatorium might be. The results were favorable and seven months after admission, the patient was discharged. She had gained over twenty pounds, looked well, and was full of courage and hope. Work was obtained for her in a private hospital, where the Superintendent took a personal interest in her health. A little later, she returned to her old place at the inn, where she also received special con-

sideration based on the understanding of her needs as represented by the social worker.

A year later, Miss Smith wrote Miss Carrington that she had been steadily at work at the inn, though occasionally she had colds and stayed in bed for a day or two. A little later, the surgeon reported that he had examined her and found her in good condition; apparently the disease in the kidney had been arrested.

Two years later, Miss Smith wrote again. She was still at the inn; her condition showed no essential change, and she was content and happy. Her employer understood the situation and was very kind; and she knew where to turn in case chronic hospital care became necessary. But it seemed to Miss Carrington safe to believe that Miss Smith had many years of usefulness before her.

COMMENT

This history illustrates the administrative difficulty of persuading States, cities, and towns to pay for suitable care for patients suffering from tuberculosis in other forms than pulmonary and laryngeal. They are not used to facing the burden of expense when the disease is in other organs. Sanatorium treatment is desirable for all types of tuberculosis unless the social conditions are so favorable that similar treatment can be carried on at home. This, however, cannot always be achieved even in families of wealth; how much less, therefore, is such chance in the home of the average hospital patient? This patient cost the State a considerable sum of money, but from every point of view, it was a good investment.

Another feature of this case is the manner whereby it came to the social worker. In many hospitals, of course, the pressure upon the social workers is such that it might seem impossible to help out the medical staff with their private patients in this way. And yet, it is not after all so difficult for a case worker to take on another patient; and certainly it is a privilege to do something for the doctors who are constantly

helping the social workers. Does this, perhaps, point the way toward the social worker in her own office where she may be called upon by physicians for their private practice? The need of medical-social work is not conditioned by the social or economic status of the patient; it is not peculiar to those who obtain the requisite medical treatment at clinic and dispensary rather than in the private office of their own physicians.

E. W.

These last sentences are very much to the point. I know that physicians are frequently in need of just such aid as these cases exemplify for the aid of their private patients. But they are not used to the idea and nothing reminds them of the possibility of getting such aid. In hospitals, they are sometimes reminded of it by their internes or by seeing the social worker in the ward.

This case is a triumph of medical care. The disease is difficult to cure or even to arrest. The necessary after-care was secured by the energy and persistence of the social worker.

R. C. C.

CASE 19

PATRICK CALLAHAN Age 38 *Married*

Seen in the Emergency Ward June 3, 1920.

MEDICAL SOCIAL PROBLEM

Pulmonary tuberculosis in a man of weak character who has absconded from justice, deserting his family.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Second-stage pulmonary tuberculosis with negative sputum.

b. *Prognosis:*
Is good with proper treatment.

c. *Treatment:*
About a year in a sanatorium.

d. *Other medical history secured by social worker:*
None obtained.

Social
(Family and patient)

a. *Analysis:*
Patient and wife are both natives of Ireland; they are Roman Catholics. They came from the same district in Ireland, but met in New York after both had been there for some years. They have had one child, a boy, now ten years old. As patient had always intended to return to Ireland, he has not become a citizen. His present wage is $14 a week, but he formerly earned from $25 to $30. He has worked as a street-car conductor, driver of a milk wagon, in a small factory as general handy man. His academic education was poor, but he is clever, well-posted, with a considerable fund of information and his own philosophy of life. He drinks to excess at times, and is then quarrelsome, but otherwise is good-natured, cheerful, friendly; is respectful to his superiors. His employer says he works hard and gets on well with his fellow employees. Wife's character under suspi-

Medical (Patient only)	*Social* (Family and patient)
	cion, but no positive information is obtained. Son accused of delinquency, but no confirmation secured.
	b. *Treatment:* Sanatorium care provided. Patient's consent secured to notify Probation Officer of patient's condition and whereabouts. Patient urged to reëstablish connection with wife and son. Attempt made to get him to assume family obligations as soon as possible and to regain his sense of duty and respect for law. Relatives in Ireland written to and reassured. Contact with patient maintained closely while in sanatorium.
	c. *Sources of information:* Employer; Probation Officer; a friend.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Not suitable.	a. *Family and patient:* Close bond between patient, mother, and sister. Patient's optimism, courage, wish to get well, and return to Ireland.
b. *Hospitals:* Sanatorium Department of the State Hospital is available.	b. So far as known, no *relatives* can give material aid.
c. *Nursing homes:* Not suitable.	c. No *benevolent individual* is interested.
d. *Convalescent homes:* Not suitable.	d. No *private institutions* are open to patient.
e. *District nurse:* Not needed.	e. State Hospital is available free, but State Sanatoria are not, as patient has no legal claim. Probation Officer in New York should be able to assist in building up patient's character.

NARRATIVE

PATRICK and Annie Callahan and their ten-year-old son Joseph lived in a tenement in a crowded section of New York City. Patrick earned good wages and was saving money toward returning to Ireland where his widowed mother and widowed sister lived on a small farm. Though his wife came from the same district in Ireland, she did not, however, share Pat's wish to return. She was a spirited creature who had acquired American ideas in the families where she had worked before her marriage. She had run away from one lonely Irish farm, and she did not believe in married couples' living with their relatives; wherefore she had no idea of going back to another Irish farm to live with the Callahans. To little Joseph, born in New York, Ireland was not at all attractive in comparison with the busy streets of his native place. In the many family arguments over the matter, Pat usually had the worst of it, the letters of his mother and sister, who were in hearty sympathy with his desires, proving detrimental to his cause rather than helpful.

From time to time there were boarders in the home, young men newly come from Ireland who added to the family income and increased the discord; for those who did not take sides with Patrick made him jealous. Moreover, there was another source of dissension; it was bad enough when Pat went off on sprees, but it was worse when he came home before he was over the effects, and wrought havoc upon doors, furniture, and crockery.

Finally the spirited Annie had him into the Family Court. Patrick was haled before the judge and put on probation for a year. He was ordered to pay ten dollars a week to the Probation Officer and to report to him as directed from time to time. Suddenly he dropped out of sight, without notice to the officer or to his family. This put the entire burden of Joseph's support on his mother, who secured work in office buildings and managed to provide for herself and her boy comfortably,

though not, perhaps, on the proceeds of that job alone. There were indications that she derived an extra income from the illegal sale of liquor; but the charge was not proved.

A few months later, Martin Brown came to the Emergency Ward of the M.G.H., where he was found to be suffering from pulmonary tuberculosis. Sanatorium treatment was recommended and the doctor called in Miss Warren, the social worker on his service, to take charge of the patient's transfer and general welfare. A slender, yellow-haired, blue-eyed Irishman, he had the winning ways of his type who make friends easily and are the more difficult to rescue from intemperance because of their lovableness. Miss Warren had a long talk with him and explained the situation that confronted him. She told him what sanatorium treatment meant and how it was to be secured, and this led logically to questions covering his history, rights, and obligations. The patient answered promptly, but his answers did not bear scrutiny. When she called attention to contradictory statements, the man owned that his name was Patrick Callahan and that he had deserted his family in New York. And he explained his reasons.

Following a quarrel, his wife had had him arrested for non-support and drunkenness. The Court had put him on probation (as told above) ordering him to support his son, but not his wife. He believed that it was all a 'put-up job' on the part of his wife and her lodgers in order to get rid of him. They were using his home (he said) for bootlegging operations, of which he strongly disapproved, and making large sums of money. He admitted that he had frequently given his wife cause for complaint; but she had also been a heavy drinker for years, though she had managed to keep the fact secret so that the Probation Officer did not know the truth.

For several months after he had been put on probation, Pat had paid regularly for the boy's support; but it irritated him to add to his wife's income which was large because of the bootlegging, and he decided to go to Canada. During the World War he had served in the Canadian Army and he be-

lieved it would be easy to get work there where he would be spared the exasperating necessity of paying ten dollars a week to his wife who had far more money than he could make. He had applied to the Court for permission to go beyond its jurisdiction, but was, of course, refused.

Then he received a letter from his mother saying that owing to conditions in Ireland she was in distress and asking for immediate aid, as her cottage needed a new roof and there were other necessary repairs. He had no money to send her, but the more he dwelt upon the matter the more strongly he felt that he ought to help her rather than to continue to give the Probation Officer every penny he could get, while his wife, owing to her illegal liquor dealings, was amply able to support their boy. Then Patrick Callahan disappeared from New York and 'Martin Brown' appeared in Boston. He had no trouble in finding work in a factory here and as soon as possible sent his mother twenty pounds. He showed Miss Warren the post-office receipts for one installment of ten pounds and two of five each.

When Patrick heard the doctor's advice, he was dismayed and rebelled against the idea of a year in a sanatorium. It required much time and effort to persuade him even to consider any such thing. When he finally gave in, his privileges under the Massachusetts laws were set before him in contrast to his probable rights as a Canadian veteran under the reciprocal arrangement between the United States and Canada. But he elected to go to the Sanatorium Department of the Massachusetts Almshouse Hospital rather than apply to the Veterans' Bureau, because he did not wish his recent court record to be added to the army record.

So far, so good. Then Miss Warren proposed notifying the Probation Officer of what had happened; but Patrick refused to allow her to do so and could not be moved to reconsider his refusal. Miss Warren told him she would not do it without his knowledge; but otherwise she made no promise of secrecy. She asked him to think the matter over and see whether he

wished to be a deserter in civil life. She was sure he would not have deserted in the face of the enemy in France. Would he not face the enemy at home?

Leaving these thoughts with him, Miss Warren consulted the doctor as to the advisability of Patrick's staying in his boarding-house for the few days that would intervene before he could be sent to the State Hospital. The doctor approved, arrangements were made with the woman in charge, and Patrick was told to report to Miss Warren two days later, prepared to leave for the sanatorium. Promptly at the hour, he appeared at the office.

Asked whether he had not changed his mind with regard to sending word to the Probation Officer, Patrick declared that he had not. Miss Warren then attacked the matter from another side. She spoke of his boy and found that there was a paternal spark smouldering beneath the resentment and bitterness against his wife. Presently he began to speak freely of the boy. He said he was a good lad and he need not worry about him, because his wife's brother, in whom he had complete confidence, would look out for Joseph. Finally he agreed to Miss Warren's declaration that Joseph had a right to the best sort of father Patrick could supply, and gave in with regard to the Probation Officer.

Patrick agreed to enter the Hospital under his own name; but he could not bear to have his present fellow workers know that he had been deceiving them, and as his mail went to his place of work, the duplicity would come out in connection with forwarding the mail. Miss Warren proposed having it sent to her from the factory, to be forwarded by her under cover to him. This plan pleased him and he went off to the State Hospital with many expressions of thanks and assurances that he meant to do better. Miss Warren told him that there would be a Roman Catholic chaplain at the Hospital and she hoped he would avail himself of the privileges of religion.

She wrote to the Probation Officer in New York explaining

the situation with regard to Patrick and asking for a summary of the court record. Several weeks elapsed without any reply. Meantime she heard several times from Patrick. In one letter he told her his employer still owed him three or four dollars and asked her if she could collect it. She could and did. Several letters came to her to forward and with each she sent him a few lines of encouragement. His responses showed that he was settling down, determined to make the best of things and to enjoy himself. His letters were characteristic, as a bit from one will show: 'The nurses are very nice and obliging and everything looks as cheery as could be expected. Some playing checkers, some playing cards, some pitching horseshoes out in the woods, and some preparing for the next world in bed.'

When the report from the New York Court came, it substantiated Patrick's story excepting in the matter of his accusations against his wife, although it was a fact that there was a lodger of whom he was jealous. The Probation Officer asked whether Miss Warren thought it better to extradite Patrick or have him undergo treatment in Massachusetts for the present until his health should be restored so far as it might be. The tone of the letter was fair and kindly; but one point impressed Miss Warren. When he had applied for permission to go to Canada or Ireland, the Court had reprimanded him severely because he said he had no intention of becoming a citizen of the United States. Was there a hint here that to one thus oblivious of his duty, the quality of mercy would be strained? In any event, Miss Warren advised against extraditing the patient.

For some months, Patrick remained at the Hospital, the interchange of letters between him and his friends going on with Miss Warren's aid. Presently the latter received a touching letter from the sister in Ireland asking about her brother's condition. Patrick had written her that Miss Warren knew his story and she begged her, in case he was not going to recover, to see that he was prepared for heaven. In her reply,

Miss Warren endeavored to cover the essential details of Patrick's physical condition and spiritual welfare. She told her that Patrick would probably be well enough to come home in six or eight months and dwelt upon the happy reunion to which they could all be looking forward.

Not long after this, a man came to the office saying that he was a friend of Patrick's from New York and wished to visit him. Miss Warren would not say where he was until she had made sure that Patrick wanted to see him. Being questioned, the man said he had lived with the Callahans for some time. He was non-committal about Mrs. Callahan, though he admitted that he would not be surprised if she drank. Certainly, the lodgers in her tenement sold liquor illegally and he could not see how Annie could be ignorant of this. He spoke well of Pat, who, he said, was not a steady drinker, but occasionally went on sprees. As for the court action, he believed Pat had not had a square deal.

Receiving Pat's consent by special delivery letter next day, Miss Warren told his friend where to find him. The aftermath of this visit appeared in a letter from Pat in which he said he was worried about his boy, concerning whom his friend had brought bad reports. He said he was going to follow Miss Warren's advice and write to his wife and son. Eventually, he hoped to take the lad to Ireland, away from bad companions and temptation.

Some eight days later, Miss Warren forwarded to Pat a letter from his wife, enclosing with it as usual a friendly note. This letter was returned stamped with the words: 'Patient discharged.' Miss Warren sent Mrs. Callahan's letter back to her with a line of explanation, and then wrote to the Superintendent of the Hospital to ask what had happened. He replied that he had given Patrick permission to go away for two days and that he had not returned. His condition had been much improved, but the tuberculosis was still active. Miss Warren reported what had happened to the Probation Officer. She told him, also, of the reports about Joseph which had caused

uneasiness on the part of his father and asked him to investigate and, if it were found necessary, to take action toward the improvement of the boy's environment.

Just over a month after Patrick left the State Hospital, Miss Warren received a letter from him from his sister's home in Ireland. He was non-committal as to how he got there, but said that he was feeling well and was following all instructions he had had from the doctors and from Miss Warren. He was in communication with his wife and boy and hoped to get them over to Ireland soon.

After this, Miss Warren heard from Patrick and from his friend in New York a number of times. All was going well with the former; he had no cough; his doctor was evidently giving him tuberculin and cod liver oil and spoke encouragingly about the outlook. In the last letter she had from him, he asked her to send at his expense the clothing abandoned by him when he fled from the State Hospital. This was carried out through the Hospital about eleven months after his leaving.

COMMENT

Cases like this show the necessity of good family case work. In this instance a social worker standing in a relation of impartiality to both parties to the trouble was needed. Nothing was gained by arresting the husband and putting him on probation when he was convinced of unfair dealing on the part of his wife. He felt that the Probation Officer did not give him a square deal. He was one who was amenable only to sympathetic treatment from one he believed to be unbiased. Therefore the psychological attitude essential to the solution of the problem was lacking. And by the time the hospital social worker began treatment, it was impossible to make the readjustments that might have been brought about earlier.

The obligations of social agencies to officers of the law is another question brought out by this history. Some social workers believe it unethical, akin to espionage, to report to

the authorities of the law concerning a runaway. But others hold that the term 'social worker' is misapplied if the welfare of society is lost sight of in that of the individual, and that in the long run it is only through frank recognition of the wider aspects of a problem that constructive work is accomplished.

E. W.

The right solution of this problem seems to me to lie in entire openness with our patient at all times. We may think it is best to bring in the forces of the law by reporting to its officers the delinquencies of a patient. But if we do so it should be with his knowledge and after fair warning. The prior problem, whether we should try to bring legal constraint into a patient's troubles, when it is through our intimacy with him and his confidence in us that we have evidence against him, is I think to be settled first by considering whether we should thereby be betraying a confidence which he had a right to think we would keep: has he trusted the social worker as he would his lawyer or his priest? If so, I think it would require very strong evidence of benefit to society accruing from our disclosure to lead us to make it. On the other hand, if we know the damaging facts against a patient by our own observation or from outside sources and have not heard them from him in confidence, the question becomes one of good judgment. Do we believe, in this instance, the patient's character being what it is, the provisions of the law and the officials now here carrying it out being what they are, that it would do the patient good in the long run to have charges made against him and very possibly to be punished?

To decide on these grounds is not to take the law into our own hands or to act as if we were superior to it. Authorities on jurisprudence tell me that there is nothing in the theory of criminal law that expects private citizens to feel any duty of initiative in running down delinquents. That is for those injured and for the officers of the law itself. An experienced social worker recently said in my hearing: 'If I were to report

all the infringements of law that I see or suspect in the course of my work, I should have time for nothing else.' The law does not expect us to constitute ourselves amateur detectives or special police agents.

It is quite another matter to give our evidence, truthfully, of course, if called upon to do so by the officers of the law. Unless and until social workers and doctors have the legal right to consider their patients' communications privileged, the social worker may be called upon to testify against her patient. But to take the initiative, and call the legal officials' attention to patients' infringements of law is no one's duty unless, as I have already said, there is an entirely obvious gain to the patient or to society in such initiative. In my experience this has rarely seemed to be the case.

R. C. C.

MALIGNANCY

(Eight cases)

NOTE

Case 20. *Robert Sawyer:* æt. 78.
Question of carcinoma of bowel with metastasis to spine; feeble-minded wife crippled by infantile paralysis.

Case 21. *Sara Moreland:* æt. 60.
Carcinoma of breast with mental disease; no money; public support.

Case 22. *Selma Ungaard:* æt. 38.
Cancer of the stomach; bronchial pneumonia; hallux valgus; pyorrhea; dependency on own earnings; broken home.

Case 23. *Inaku Morekyo:* æt. 48.
Cancer of the stomach; post-operative pneumonia; bronchiectasis; institutional care at public expense.

Case 24. *Feodor Tobenski:* æt. 46.
Carcinoma of kidney; ample financial resources; no home; no one to take responsibility for patient.

Case 25. *Juliette Thibeault:* æt. 19.
Sarcoma of spinal cord; deserted wife dependent on relatives.

Case 26. *Minnie Lourie:* æt. 41.
Metastatic carcinoma; broken home; dependent on relatives.

Case 27. *Tito Ferrari:* æt. 31.
Sarcoma of leg; dependency on public support.

NOTE ON SOCIAL WORK IN CASES OF MALIGNANCY

This is the group of patients which ordinarily can receive only limited attention from the social worker, patients for whom little can be done except to make them as comfortable as possible while they drift toward the end. The social worker must, however, broaden her interpretation of 'comfortable' to make it cover many other things than physical ease; and she must rely most of all on those intangible spiritual means which the maintenance of friendly relations may foster. A letter, a flower, a visit whenever she is near and can snatch a few minutes, the introduction of a friendly visitor who will reënforce her in such ways — these trifles, brought to bear after the immediate problem, adequate nursing, and medical attention, have been attended to, go far toward making the situation endurable.

In the families of these dying patients, moreover, the social worker has a definite opportunity. She may help them to bear a great ordeal; and frequently she encounters complicated social problems demanding prolonged treatment. The solution of such problems may prevent the breaking-up of the family after the death of the patient and the knowledge that the problem is in skilled hands enables the latter to die in the peace of mind that comes from the consciousness that some one is carrying the burden he lays down.

CASE 20

ROBERT SAWYER Age 78 *Married*

Admitted to ward November 13, 1920. Discharged December 19, 1920.

MEDICAL SOCIAL PROBLEM

Question of carcinoma of descending colon; question of metastasis to cervical spine in aged man with invalid, feeble-minded wife, and very young child.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Question of carcinoma of descending colon; question of metastasis to cervical spine; arterio-sclerosis.

b. *Prognosis:*
Is uncertain. Patient will probably not live long.

c. *Treatment:*
Patient must be under supervision of L.M.D. for the administration of opiates. He will probably need bed care.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient is a native of England; Roman Catholic. His early youth was spent in the British Army. He saw service in India during the great Mutiny. His first wife was an Irish woman who was a Roman Catholic; he became a convert to her religion. They had several children born in India; emigrated to the United States when children were young, as wife's relatives were here and were doing well. Wife died after forty years of marriage when she and patient were each sixty-eight years old. One and one half years later patient remarried. His second wife, also an Irish woman, was at the time of her marriage only forty-one years old. She had been lame from childhood. One child — a son — was born of this marriage. Patient earns $70 a month, and besides receives all vegetables, fruit, eggs, and milk. Rent is $10 a month.

Medical (Patient only)	*Social* (Family and patient)
	Patient is naturalized citizen; has a legal settlement in town where he lives. Wife is an invalid, unable to walk. History indicates infantile paralysis as a child. L.M.D. thinks mental condition large factor in present invalidism. Son, Harold, is apparently in excellent health. Patient can neither read nor write, but has a real education of non-academic type; large fund of information which he uses well. Wife can read and write but poorly; writes extremely incoherent letters. Harold is doing well in school where he is in the second grade — slightly retarded for his age of nine years owing to frequent absences occasioned by having to wait on his mother. Patient is a laborer on an estate where he was employed in the stables. He also does all the housework at home. Patient is an honest, God-fearing, hard-working man devoted to his family and loyal to his obligations; with excellent conception of civic and personal duties; uncomplaining, cheerful, courageous, friendly, confiding, delightful personality. Wife is a querulous, whining invalid of marked mental abnormality, deficient memory, shrewd in getting her own way; no sense of value of money; utterly incapable of training Harold; oblivious to her surroundings as long as her childish love of sweets is gratified. Harold is timid, obedient, affectionate; has no real understanding of the deceit involved in concealing from patient his

Medical
(Patient only)

Social
(Family and patient)

absences from school, and his purchases for his mother.

b. *Treatment:*

1. *Plan:* Meet patient's need of chronic care; place wife in suitable institution; secure guardian for Harold and see that patient makes his will; explain social situation to L.M.D. and coöperate with him if he so desires.
2. *Result:* Patient supervised until his death; wife placed in hospital for chronic patients; patient's legal affairs put in order; guardian appointed for Harold.

c. *Sources of information:*
Employers, relatives, L.M.D., pastor.

2. Therapeutic Assets

Medical

a. *L.M.D.*: L.M.D. who sent patient into M.G.H. will take charge.
b. *Chronic hospitals:* Are available.
c. *Nursing homes:* Are available.
d. *Convalescent homes:* Are not suitable.
e. *District nurse:* Will go in daily, or as often as needed.

Social

a. *Family and patient:* No help can be expected of wife. Patient realizes his condition and will follow orders implicitly. His mental attitude will help. His home is entirely unsuitable and he cannot return there.
b. *Relatives:* Patient's son and daughter from first marriage are devoted to him and will do everything possible; will also help in planning for wife and Harold.
c. *Benevolent individual:* Patient's employers are deeply interested; will give financial aid to any amount for patient's comfort.
d. *Private agencies and institutions* are available for patient and Harold.
e. *Public agencies and institutions:* May be called on for care of wife. Are not needed for patient and Harold.

NARRATIVE

As he listened to Mr. Sawyer's story, the doctor in the ward said to himself that if the old gentleman was to be able to close his eyes in peace he must have the services of a social worker. Miss Carrington was accordingly informed of the social aspect of the case before the physicians had completed their study. And truly the situation was so complicated that it was small wonder that it was distressing to Mr. Sawyer to think of it. And yet he could not put it from his mind; even the opiates given him to insure relief from torturing pain could not wholly neutralize his anxiety over the future of his wife and little son. Fortunately, however, he was shortly relieved of that. While medical treatment in his case could only be palliative, social treatment could be remedial. The assurance given Mr. Sawyer that plans would be made for his wife and little boy enabled him to face the future without fear.

Partly from the old gentleman himself, partly from his older children, Arthur Sawyer and Jane Littlefield, Miss Carrington gathered the main facts of his history. His son and daughter had never failed him even though they had disapproved strongly of their father's remarriage because of the woman he chose, or rather, by whom he was chosen. When they saw this woman, of about their own age, installed in their mother's home, using, abusing, and discarding her cherished household goods, they endured it in silence only through love for their father. When, three years after her marriage, she became practically bedridden, they stood by, helping with the housework, the care of the two-year-old baby, and the bills, until Mr. Sawyer pulled himself together and insisted upon carrying the burden on his own shoulders. Not one word of complaint or criticism of the second wife did Mr. Sawyer or his children ever utter. The former bore the trials, the humiliation, the grief with silent dignity; the latter looked on with silent respect and sympathy. For five years this went on until Mr. Sawyer felt he could no longer stand a certain pain he had

which increased constantly and which he attributed to a strained back. He sought medical advice and his doctor, who could not make a diagnosis, sent him to the Hospital for study.

Realizing that his life was nearing its end and that he could no longer hold his home together, Mr. Sawyer was troubled only because of his wife and child; but shortly Miss Carrington was able to reassure him as to their welfare. She told him about the facilities for institutional care of a chronic invalid such as Mrs. Sawyer and for home care of dependent children. Mr. Sawyer was anxious to have his daughter, Mrs. Littlefield, take Harold into her home, both because he trusted and loved her and because she had been an excellent mother to her own children, the youngest of whom was about Harold's age. Miss Carrington did not commit herself to this plan fully, as she wished first to study all sides of the question; but she explained to Mr. Sawyer how guardianship of the child could be transferred to some suitable person. She spoke to him also in regard to wills, trustees for minor children, and similar matters; for he had one thousand dollars in the bank which had been given him a year ago by his employers, Mr. and Mrs. Robinson, in appreciation of his long service to them.

His mind being relieved, Miss Carrington visited his home, which consisted of three rooms on the ground floor of an old frame house in the rear of a lot which had a shop on the street frontage. The house, unattractive, in poor repair, without modern conveniences, still bore traces of an earlier stage when it had been a comfortable farmhouse. The one advantage it offered the Sawyers was that the sun could still shine into their windows. It shone now upon such disorder and dirt, however, as even a social worker rarely encounters. The furniture was of the most meagre description, the only source of heat being a vile-smelling oil stove.

Wrapped in filthy blankets, with pillows behind her, Mrs. Sawyer was huddled up on the side of a bed, her feet on a footstool, with what was once a handsome down puff partly over

them, partly dragging on the floor. Her coarse grey hair hung in matted locks about her face. She looked as if she hadn't washed her hands or face for weeks. She took the arrival of a visitor calmly. Yes, she was Mrs. Sawyer. No, she was not alone, for Harold would be here in a minute with a pie she had sent him out to purchase, and a relative would come in soon to clean up, as she did every day. Yes, she would like to know how her husband was getting along.

Almost from the first words spoken, Miss Carrington, who had been led to expect only chronic invalidism, realized that there was something more. She proceeded with caution, drawing out Mrs. Sawyer first on one subject, then on another. Her answers were childish, but shrewd when they concerned herself. Evidently she expected her husband to return home soon ready to take up his work again outside and within; meantime, she could get along with Harold and the daily visits from the relative. The latter brought food every day, but as it wasn't the kind Mrs. Sawyer fancied, she gave it away and Harold bought at a bakeshop near by the pies, cakes, cookies, and candies which both he and she preferred to plain food. The relative (there was no reason why she should not have named her husband's daughter, Mrs. Littlefield) also cleaned up this room; but of course with the boy, his cats, and his dogs, it soon got into disorder again. And, after all, what was the use of doing anything which had to be done over and over again? Apparently, dust, dirt, unwashed dishes, soiled bedclothes, and filthy floors were minor matters to Mrs. Sawyer.

And yet, very shortly afterwards, she was complaining bitterly of being neglected. Miss Carrington felt constrained to make the effort to get Mrs. Sawyer to understand her husband's condition, though she realized it was in vain. As she went on to speak of the impossibility of his coming home and the necessity of making some plans whereby she and Harold would be made more comfortable, Mrs. Sawyer rocked back and forth muttering that she would never leave home. She

demanded that Miss Carrington should send her a trained nurse at once, declaring that Mrs. Robinson, her husband's employer, was deeply interested in her and would pay for the nurse. When Miss Carrington suggested a good hospital instead, Mrs. Sawyer refused with tears and wails.

At this point Harold came in with a juicy apple pie in his hands. Pausing long enough to look at it, Mrs. Sawyer clasped her child in her arms and began to scream that no one could make her leave her home. She asked him what would become of him when they took his mother away from him, and Harold, a timid little fellow, lifted up his voice and wept in concert. The air resounded with lamentations which Miss Carrington was powerless to quell, when suddenly Mrs. Littlefield came in. Promptly she seized upon the pie and washing some plates served it at once. The diversion was so successful that Miss Carrington added Pie to her Social Pharmacopeia as a remedy for tears and hysterics. After Mrs. Sawyer had eaten, not all she wanted, but all that Mrs. Littlefield considered wise at that hour of the afternoon, Miss Carrington resumed her efforts, Mrs. Littlefield meanwhile devoting herself to cleaning up and straightening out the disorder and confusion. By the time she had finished, Miss Carrington had come to the conclusion that she could not hope for intelligent coöperation from Mrs. Sawyer, and since it wasn't possible to plan with her, it would be necessary to plan for her. Contenting herself, therefore, with leaving Mrs. Sawyer in a cheerful frame of mind as the result of her visit, with some definite information of her husband's condition, and in a much more tidy home as the result of Mrs. Littlefield's visit, she took her departure.

Further consultation with Mr. Sawyer and his son and daughter brought forth more information concerning Mrs. Sawyer's peculiarities. She ran up large bills at the local shops, mostly for candies, cakes, and pies which she bought through Harold. She patronized every itinerant vendor who came to the door, buying the most useless things either on the

initial payment plan or with the small amount of cash her husband always left in the house for her use in case of emergency. Mr. Sawyer was, therefore, constantly in debt. Once he tried the experiment of notifying the shops not to give his wife credit; whereupon she made purchases on several occasions and had the bills sent to her husband's employer, who paid them. This sort of thing, together with his wife's frequent secret appeal to his employers for gifts, was unspeakably humiliating to Mr. Sawyer. His older children shared the feeling; for Mr. and Mrs. Robinson had been kindness itself to them for nearly a third of a century, and the idea of imposing on their generosity hurt them keenly. And even this was not all. Mrs. Sawyer had drunk heavily so long as whiskey was legally available and even now she managed to get it occasionally. This habit accounted for the meagre furnishings. Piece after piece of the furniture, so carefully gathered during the forty years of Mr. Sawyer's life with his first wife, had disappeared from sight, Mrs. Sawyer claiming, when anything was missed, to have given it to the rag-man.

It was decided that Mr. Sawyer was to go to his daughter's home upon his discharge from the Hospital, as neither Mrs. Littlefield nor her brother would consider anything else for him, and he himself approved of the plan. He would be right round the corner from his own home and would have every opportunity of seeing that all was well there until such time as a final plan could be made for Mrs. Sawyer. Meantime, his will would be made safeguarding his one thousand dollars for Harold's education — both Mrs. Littlefield and her brother renouncing any share in the money — and a guardian would be appointed for the child.

All this time Miss Carrington had been carefully observing Mrs. Littlefield and had come to have a high opinion of her. Visiting her home, she found it clean, orderly, and very comfortable; she saw the children and their father who showed the effects of the love and attention of a good wife and mother. She noted Harold's fondness for his half-sister, whom he called

'aunty' when he called her anything. She saw the pastor of the parish and the family physician, both of whom corroborated her judgment and approved of Mrs. Littlefield as Harold's guardian. Accordingly, proceedings were instituted toward this end with the help of the Legal Aid Society.

Then Miss Carrington turned again to Mrs. Sawyer, who, as she explained to the relatives, was not wholly to blame for her conduct owing to her mental condition which constrained them to deal with her as they would with a child. No help was to be expected from her only relative, an uncle, an unstable man, known to be a hard drinker; but it was felt that he was entitled to know that a crisis in his niece's life had arisen and to join if he wished in any plan made for her. He declared that he could do nothing and gave the Sawyers *carte blanche* to go ahead as they thought best. Mr. and Mrs. Robinson, upon whom Miss Carrington called, also disclaimed any desire to help. So long as he should live they intended to pay Mr. Sawyer his wages, and they wished to assume all bills incidental to his care, living or dead; but they saw no reason why Mrs. Sawyer should become their pensioner. They were willing, however, to pay down five hundred dollars, if for that sum she could be admitted to an institution that would care for her for the remainder of her life. As there was no such place, they agreed with Miss Carrington that there was no other alternative to the City Hospital for Chronic Invalids.

Both the pastor and the family physician approved of this plan. The doctor believed Mrs. Sawyer's condition to be hopeless. After her marriage, he explained, her weight had so increased as to make it difficult to use the leg, which had always been weak, owing, probably, to infantile paralysis in her childhood. This and her mental weakness rendered it easy for her to lapse into a condition of semi-invalidism in which she refused to make any exertion. From long acquaintance with her, he believed her feeble-minded, with a mental age approximating ten years. He saw no necessity of having her examined by a psychiatrist.

Miss Carrington accordingly made arrangements for the proper city official to interview Mrs. Sawyer in her home and offer her care in the City Hospital for Chronic Illness. But as the only result was an hysterical scene in his presence similar to the one Miss Carrington had witnessed upon her first visit, it seemed well to wait until the logic of events should convince Mrs. Sawyer of the wisdom of accepting their plan.

This was brought about very shortly. In the first place, it was made plain to her that Mr. Sawyer could not return home; Harold saw him brought to Mrs. Littlefield's in the ambulance and told his mother of his father's deplorable condition. Mrs. Robinson refused her request to send in a trained nurse and would not even pay a neighbor to go in and care for her. Harold was sent back to school, and his mother was left alone all day with no one to bring her the unsuitable dainties she craved, her excellent meals being taken in by Mrs. Littlefield. Credit was cut off at the shops by Mr. Sawyer's orders, which were obeyed now that it was generally known that he was dying. Finally, her uncle refused to listen to her plea for support. In the face of all this, the advantages of a comfortable, clean hospital with good food to eat and nurses and doctors to look out for her — advantages which were constantly kept before her mind — began to take on a different aspect. Mrs. Sawyer reconsidered, and three weeks after her husband left the M.G.H. she entered the City Chronic Hospital.

On the whole, she was content, though she wrote to a number of her former neighbors asking for gifts of goodies. Her attitude toward her husband at this period showed that she did not in the least comprehend his condition; moreover, of true wifely affection or concern, there was no trace. What she missed was not her husband, but his financial support, the physical care he had always given her, the freedom to indulge herself which he had afforded her to an almost unlimited extent. She would even have forgotten her boy had he not been taken to visit her at regular intervals.

The guardianship proceedings went through without hitch;

and the will was duly executed. Though he suffered greatly, Mr. Sawyer's mind was at rest. Sometimes, as Miss Carrington sat by his bed during the little visits he begged for, he would entertain her by highly diverting stories of his early life, his gift of narration including powers of keen observation and inference. Again he would be drowsy from opiates and as he lay between waking and sleeping, his daughter, sitting on the other side of Miss Carrington, would tell of the goodness, the sweetness, the humor that had characterized his whole life. Miss Carrington, like all social workers, watched at many a bedside where only sin, misery, and wretchedness were displayed; but from these visits to Mr. Sawyer and his daughter, she gained renewed faith in the nobility and beauty of human nature.

Often little Harold would run in. Now that he lived with Mrs. Littlefield, he seemed another child, in his smiling confidence as well as in his chubby, rosy face. He seemed like another of the Littlefield children, grandson to his father. When Mr. Sawyer referred to his children, he meant only Arthur and Jane, and 'my wife,' of whom he talked constantly, was his first wife. The other was *Catherine* or *Mrs. Sawyer*. Not that he showed any lack of respect or want of consideration for her; it was simply as if he had had only one wife and that Catherine bore a different relation to him.

The end came about three months after Mr. Sawyer had left the Hospital. After that for a number of months, Miss Carrington occasionally saw Mrs. Littlefield and Harold. Mrs. Littlefield, though exhausted from the strain of nursing her father, for whom she had not been willing to allow even the district nurse to do more than say what was necessary, relaxed none of her efforts for her family. Harold was in admirable hands and perfectly happy.

Practically the same could be said of his mother, whom Miss Carrington visited in the Hospital only to find herself utterly forgotten. She had a long talk with Mrs. Sawyer without her manifesting any interest in who she was; and as nothing was

to be gained by disclosing her identity, Miss Carrington withheld it. Satisfied that all was well with her and with Harold, she withdrew from the case.

Since then she has had no regular contact with the family, though if she happens to be in the neighborhood, with a moment to spare, she likes to drop in for the refreshment of a word with Mrs. Littlefield. In this manner she has learned of the continued interest in the family shown by Mr. and Mrs. Robinson. Mrs. Sawyer, especially, profits by their generosity. Harold does well at school and the one thousand dollars in the savings bank is drawing compound interest to give him a start in life later on, his present expenses being met by his brother and sister who have long since been converted into uncle and aunt. He visits his mother, and both he and she are looking forward to the time when he is a man and can take care of her.

COMMENT

This case illustrates the strategic point occupied at times by the hospital social worker. This patient was intelligent and of excellent principles and intentions; but he did not know how to fulfill his obligations after he became unable to carry them out personally. His son and daughter would have carried out his wishes to the extent of their ability; but they did not know how to cope with the problem presented by the mental condition of the second wife.

There is reason to believe that Harold has been rescued from grave danger. Certainly the end of an honorable life was made peaceful and serene because of the fact that the hospital had not only a physician who recognized a social problem, but a social worker whose experience fitted her to solve it.

E. W.

The fact is that Mrs. Sawyer was forced to go to the hospital against her will. Social workers are beginning to agree that the use of force or 'the whip hand' in dealing with those

whom they try to help, is rarely justified and always needs to be explained and defended. It seems to me that the feeble-minded, like the insane or delirious, are at times rightly to be controlled by force when persuasion and reasoning are of no use. But we must first be as sure as we can that nothing is to be accomplished by reasoning or by kindness, and then that the end to be attained is one that the person whom we are going to force would approve of if in their right mind and capable of reasoning. Under these conditions and as a last resort (or in emergencies) the use of force is right.

It may, of course, be said that no physical force was used on Mrs. Sawyer in this case, and that in the end it was her own choice to go to the hospital. But the cutting-off of the food supplies and of the care and companionship which she was used to is not an appeal to reason. It was entirely justifiable in this case, I think. But we can all agree that such methods should be used only under the conditions above specified.

R. C. C.

CASE 21

SARA MORELAND Age 60 *Single*

Admitted May 12, 1920. Discharged May 31, 1920.

MEDICAL SOCIAL PROBLEM

Carcinoma in an old woman without money or relatives to care for her.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Carcinoma of the breast.

b. *Prognosis:*
Patient may live some years, but metastasis will probably occur.

c. *Treatment:*
Right breast has been removed. Sterile dressings will be necessary on discharge. Patient to have supervision at the Out-Patient Surgical Clinic.

d. *Additional medical history secured by social worker:*
Patient has been an inmate of a State Hospital for Mental Diseases; diagnosis, dementia præcox, hebephrenic type.

Social
(Family and patient)

a. *Analysis:*
Family is of English stock, long settled in New England as farmers of their own land. Parents born in Massachusetts are both dead. Patient has one sister, age 64, who is also single. Family life was uneventful until eviction from farm. Since then, constant litigation and turmoil with need of public aid. Farm, valued at $15,000, was bequeathed to patient and sister by parents. After farm came to them they mortgaged it and lost it. Were swindled out of proceeds of mortgage. Not self-supporting after that. Legal settlement in native town forfeited. No other acquired, but State settlement possessed. Mother died of tuberculosis. Father of cerebral hemorrhage. Sister has been patient at State Hospital for Mental Diseases; diagnosis, arterio-sclerotic dementia. District schools were attended resulting in fair degree of education. Patient and sister both have done housework and factory work. Sister is pleasant and sociable, but is reserved in

Medical
(Patient only)

Social
(Family and patient)

making friends. Simple in a childlike way, revealing weak mental equipment; has many persecutory ideas. Is rather unclean. She has a great fondness for animals, especially cats. Has no sense in handling money. Has no immoral tendencies. Patient has affable manner; makes friends rather easily. Is positive in dominating sister whose fondness for cats she shares. She is unclean, but superficially makes rather good appearance. Has lost their joint inheritance through foolish investments, but has no realization of this.

b. *Treatment:*
Institutional care is desirable for both patient and sister. Failing this, public aid in their own home with supervision. Restoration of home to sanitary conditions.

c. *Sources of information:*
Red Cross Home Service; Overseers of Public Welfare; District Nurse; Commission on Mental Diseases; Chief of Police.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Is not needed as long as patient can attend clinic.
b. *Hospitals:* Chronic type is desirable, but not imperative as yet.
c. *Nursing homes:* Not suitable nor possible financially.
d. *Convalescent homes:* Recommended, but refused by patient.
e. *District nurse:* Is necessary.

Social

a. No help can be expected from sister. Patient's courage and self-reliance are valuable. Home is comfortable when clean.
b. No *relatives* who can help.
c. No *benevolent individual* interested.
d. *Private agencies and institutions* are not available.
e. *Public agencies and institutions* are suitable and available.

NARRATIVE

Mrs. Barton, of the Red Cross Home Service, telephoned one day that she had been asked to investigate the needs of two old women, Sara and Maria Moreland, unmarried sisters, who lived in a town in eastern Massachusetts. The district nurse had reported to the Overseers of Public Welfare that Sara was ill and that the home was filthy. The Overseer had sent in the City Physician who had diagnosed the illness as cancer of the breast and had sent the patient to the M.G.H. for surgical treatment. Sara had been going out by the day doing housework, earning nine dollars a week; while Maria had evidently been carrying on a junk business, as the house was overflowing with all kinds of old, worn-out things, with an immense accumulation of old magazines. Mrs. Barton said the home was in such shocking condition that she would like to get Maria out while her sister was away so as to have the house fumigated and put in order. That meant, however, not only providing for Maria meantime, but for half a dozen cats to which the sisters were devoted. Mrs. Barton asked my assistance in finding temporary homes for them as well as in persuading Sara and Maria to allow the city authorities to fumigate the home and destroy some of the trash.

After considerable difficulty, boarding-places were found for the cats, but there was no persuading the old ladies to allow the cottage to be fumigated. Let the authorities dare make any such attempt and they would see what would happen! If so much as a magazine were removed, Sara declared that they would sue for damages. The idea of a struggle with the agents of the law seemed to put new life into the invalid. She had been to law before, it came out, and she told with pride of more than one occasion when victory had perched on her banner. She had even been successful in getting her release from a hospital for the insane.

This information furnished a clew to those of us who were trying to solve the problem of Sara's and Maria's future. Fol-

lowing it up, we learned something of the more remote history of the old ladies. Some ten years before, the public authorities in a rural community in western Massachusetts had a difficult problem on their hands in the person of Sara Moreland, who had lost her own property and that of her sister through foolishness and credulity and had reached the point of want and yet refused to work. They sent her to a State Hospital for Mental Diseases where she was under observation for ten days. The diagnosis, dementia præcox, having been made, application was made to the judge of the district in which the hospital was located for Sara's commitment to the institution. The judge, however, believing that the judge of the woman's home district should decide the matter, refused to act. And as action was not taken elsewhere, Sara returned home.

Some eleven months later, another crisis arose, centering around the other sister. It seemed best to send Maria for observation to another hospital for mental diseases. She was held a month, then sent home for a trial visit, and finally, six months later, was discharged from supervision by the institution as capable of self-support. She was said to be suffering from arterio-sclerotic dementia.

After this, the sisters worked in a local factory, the Overseers of Public Welfare giving them aid off and on, as they could not wholly support themselves in this way. They weren't particularly grateful for this help. Indeed, they felt that everyone was against them. This general persecution had begun, they claimed, with their cousin, who, incensed at Sara's refusal to marry him, had been responsible for their loss of their farm through foreclosure of the mortgage; and the neighbors and the town officials had carried it on. They were not allowed to keep their dead cats in the cellar until a suitable occasion arose for burying several at once; and Sara was denounced for buying expensive coffins for her pets. Finally a crisis arrived. The authorities would not countenance eight dead cats in the cellar, and Sara and Maria, migrants at fifty-five and sixty, shook the dust of their native town off

their feet and departed. Between that moment and the time when they appeared in the town where they were living when Sara was sent to the M.G.H., this history is a blank.

When Sara was ready to leave the Hospital, we tried to persuade her to go away for a little convalescent care before returning home, but she was unwilling to do so. Therefore, the district nurse of the community was asked to go to the house to dress the wound. Although the authorities had not been allowed to fumigate, the Red Cross had done what was possible to make the place fit to live in, and Sara was much pleased with the change she found. She settled down to live on aid from the Overseers which she attempted to supplement by writing stories. Her reward, however, consisted in her enjoyment of the occupation. For about a year she came into the clinic off and on. Her condition was comfortable and she was almost always in good spirits. Then a second operation was found necessary, as the cancer had developed in the other breast, and she came to the surgical ward a second time. During this second period, though she suffered no great pain, she was often very uncomfortable. But she never complained and always made a merry occasion of her visits to the House Social Service Office.

After her discharge, she came in for X-ray treatment by which it was hoped to prevent further development of the disease. Six months after the second operation, she came to the Emergency Ward with a severe hemorrhage from her breast. As the surgeons could do nothing more for her, she was not admitted to the Hospital. It was plain that Sara now needed permanent hospital care; but the one desire of the old lady was to get home again. As one of the privileges of living in a democracy is that of being uncomfortable if we will have it so and if it doesn't interfere with the freedom of others, we did not try to force her to act against her inclination, but telephoned to the local authorities suggesting that they send their ambulance to take her home.

The home conditions had, however, again become beyond

endurance, and the officials felt that drastic action was warranted. They decided to send Sara to the State Hospital at once and to have Maria join her there as soon as possible. The Social Service Department of the State Hospital arranged to have one of their workers escort Sara to the Hospital. She went under protest, but without making any disturbance, and it seemed as if she was satisfied to have her desire to be uncomfortable overridden. Her old spirit flashed out as she declared that at last she was going to get some benefit from the State out of all the money that she had been paying in taxes for years and years!

Not long afterwards, Maria joined her sister at the Hospital, and the old ladies settled down contentedly, enjoying the cleanliness and comfort, not even deprived of the society of their favorite pets, for there were a number of cats in the institution. All this was a great relief to those who had been worried about their forlorn old age.

COMMENT

This history, like many histories of mental diseases, shows a lack of coördination of the medical and legal elements in the treatment with resultant difficulties for the patients and for the community. The ultimate cost to society of this case was heavy, involving as it did total support of two women whose own means would have sufficed for their needs had their property been handled by a suitable person. The old ladies would have been also much happier in that case, for unrestricted liberty that leads to general mistrust and suspicion fails to bring any genuine satisfaction.

Had there been early recognition of their inability to manage their affairs for themselves and had suitable arrangements been made by the State for the sort of custodial care these women required (perhaps in a colony adapted to the needs of such persons), they might have been useful members of society, enjoying quiet, peaceful lives. Not that the outcome would have been different in all respects; but Sara and Maria

would have lived among persons who understood them, and the community at large would have been spared unnecessary trouble and annoyance. Everyone seems to have done as well as possible under the circumstances, but circumstances can sometimes be changed by human effort. Proper provision for such cases can and will be made by the State as soon as it is generally understood that such provision pays in terms of human happiness and of effective use of public moneys.

E. W.

The comment made at the end of the last case might be repeated here, as this is, I think, another good example of the proper use of force in social work, though in this case the force was applied by the State authorities instead of private individuals and so was probably less resented.

R. C. C.

CASE 22

SELMA UNGAARD Age 38 *Widow*

Admitted October 20, 1921. Discharged December 1, 1921.

MEDICAL SOCIAL PROBLEM

Gastric carcinoma in a widow with several minor children. Probable necessity for public aid.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Gastric carcinoma; bronchial pneumonia; hallux valgus; pyorrhea.

b. *Prognosis:*
Recurrence of the carcinoma is to be anticipated within a year or two with fatal termination.

c. *Treatment:*
Convalescent care on discharge from M.G.H. Complete set of false teeth. Eventually chronic hospital care.

d. *Other medical history secured by social worker:*
Prolonged exposure to tuberculosis.

Social
(Family and patient)

a. *Analysis:*
Patient is a native of Norway; a Protestant; has been widowed twice; has one son of five in the United States as well as several children in Norway; has supported herself and son by washing and cleaning in private homes, her earnings averaging about $15 a week, her rent being $2.50 a week. For the past seven years she has lived in the same town in Massachusetts. She has little education, although she can read and write in English as well as in her native tongue; is a good mother and a faithful worker, optimistic, amiable, and confiding. Oscar, her youngest child, is a beautiful boy of average intelligence. Nothing definite is known of the other children.

b. *Treatment:*
Patient encouraged to make effort to recover. Advised about bringing children to United States. Convalescence provided for. Coördination of various sources of help. Supervision

Medical (Patient only)	*Social* (Family and patient)
	over nine months. Attempt made to follow up in a foreign country in anticipation of need of further medical treatment.
	c. *Sources of information:* Former employers; old M.G.H. record; social agency.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: No present need of a physician.	a. Patient's character will aid her recovery. Home not suitable for convalescence, although comfortable.
b. *Hospitals:* Are not needed.	b. She has no relatives in the United States except a sister in the South who can give no help of any kind.
c. *Nursing homes:* Are too expensive for convalescence.	c. The physician and his wife who employed her are ready to help materially and in other ways.
d. *Convalescent homes:* May admit patient for bed care as an exception.	d. Social agency in her home town knows her and will supervise and aid after she returns home.
e. *District nurse:* Not needed.	e. The State will assume the guardianship of patient's son, Oscar, when necessary and will admit patient to a chronic hospital at any time.

NARRATIVE

Oscar Ungaard, a Norwegian who had lived some four or five years in the United States, died of pulmonary tuberculosis in July, 1918, in a town about eighteen miles from Boston. His savings having been consumed during the year he had been ill at home prior to his death, the local social agency looked after the widow and eighteen-months-old son whom he left. Three months later, the widow, Selma Ungaard, came to the M.G.H. for examination. Mrs. Ungaard said that she was not ill, but very tired.

The examining physician found indications of an old in-

active tuberculous process in the glands and lungs; the X-ray confirmed the clinical findings, and a provisional diagnosis of pulmonary tuberculosis was made. The doctor recommended that she wean her baby at once and that she have a good rest, continuing, meanwhile, under medical supervision. For this he sent her to the Social Service Department.

Here, the salient social facts having been secured, a plan of treatment was outlined. It was decided to leave the patient to the supervision of the local social agency and to the tuberculosis nurse of the local Board of Health, the latter being known to Mrs. Ungaard, as she had supervised the care of her husband during his last illness. Mrs. Ungaard was satisfied with the plan, and the social worker wrote to the nurse giving the doctor's recommendations for the mother and baby. After assuring herself a week later by means of a telephone call that the nurse had received the letter, the social worker closed the record at the M.G.H. and left the patient in the care of the local medical and social agencies.

Three years later, one of the staff physicians at the M.G.H. came to me one autumn day to tell me about a woman for whom he had arranged admission to the wards. She had worked for him at his summer home and seemed to him to have something wrong in her stomach in addition to trouble in one of her feet which handicapped her at work. At his request, her little son Oscar had been placed in a foster-home by a children's agency for the period of her hospital treatment, and the doctor asked me to arrange for convalescent care for Mrs. Ungaard after her discharge. He said that the surgeons intended to correct the trouble with the foot and then transfer the patient to a medical ward where treatment of the gastric symptoms would be undertaken.

As soon as the patient, who turned out to be the Mrs. Ungaard described above, was admitted to the wards, I visited her, finding her a pathetic, emaciated little creature with a waxy skin. When I told her who had sent me, she was all gratitude for the visit. Though she spoke English imper-

fectly, she understood readily and enjoyed my daily visits and those of a volunteer in the department whom I asked to go in and chat with her now and then. The physician and his wife for whom she had worked, and to whom she was absolutely devoted, came to see her regularly and she accepted their advice unquestioningly.

The record made at the time of her visit to the Out-Patient Department in 1918 was proved to be incorrect in several respects. She talked little of her past life, but her story was gradually gathered from fragments that came out. She had been twice married, both husbands having died of pulmonary tuberculosis. The first one, also a Norwegian, had brought her to the United States before the birth of their first child. When the latter was two years old, her husband had fallen ill and had insisted upon their returning to Norway. There, after two more children were born to them, he died. The widow made a vain attempt to support herself and the children, then returned to the United States, leaving the children with different relatives who lived on farms. She worked as a servant in Massachusetts for a number of years before she married another Norwegian with whom she had become acquainted. Never relinquishing her plan to save enough money to bring over the children in Norway, she went on working even after her son Oscar was born.

After the death of Oscar's father, the local agency helped her until she was able to work again, since which time she had managed to accumulate a few hundred dollars. But just as she was about to send for the children in the preceding spring, her health had begun to fail, and she had had to postpone it. She had no doubt of her ultimate recovery, but meant to give herself a year in which to get strong. She did not worry about her future, as her relatives reported her older children well and strong; they were now old enough to work, and when they came over could support her if it should be necessary. For the present, Mrs. Ungaard resigned herself to the care she was receiving, content in the knowledge that Oscar was in good hands.

The operation on her feet having been performed and Mrs. Ungaard having come through it fairly well, she was transferred to a medical ward where the gastric trouble was studied. Unexpectedly a diagnosis of malignancy of the stomach was made and an operation advised. The seriousness of the operation was explained to her in guarded terms by the physicians, who did not want her to be frightened. As she had no affairs to be put in order before running the risk of death, it seemed fair to let her have the benefit of ignorance. I may add here that, by express orders of the doctors, she was never told of her diagnosis.

The surgeons removed about one third of her stomach. She stood the operation well so far as the shock was concerned, but developed bronchial pneumonia which nearly resulted in her death. For days she barely survived; then, after her physical condition began to improve, her mental attitude held her back. She had no desire to live.

Every possible means of arousing her was tried. The physician and his wife, Mrs. Ungaard's former employers, were kindness itself and made every effort to discover some way of awakening her interest in life. Finally it was suggested to her that by attempting to eat something she try to gain strength enough to see Oscar. It was touching to see her try to swallow food; she could not understand why she had no appetite, for she did not know she had little stomach left to crave food. The stimulus worked, however, and she began to gain ground, although unfortunately Oscar developed an acute ear trouble for which hospital treatment was necessary; excuses and subterfuges were necessary to account for the postponing of his visit.

The dental consultant had advised the extraction of the patient's teeth, and finally the time came when the physicians felt it safe to have this done. And soon after that, as it seemed clear that Mrs. Ungaard could not recover strength in the Hospital, plans for bed care elsewhere were made. Since there was no money to pay for her care in a private nursing

home, the only resource seemed to be the State Hospital, which, however, was open to the same objections as the M.G.H., wherefore the admitting physician of a convalescent home was appealed to in her behalf, and though he did not ordinarily admit patients requiring so much care as Mrs. Ungaard needed, he relaxed the rule in her case and took her in.

She spent many happy weeks at the convalescent home, her condition improving almost from the first. Everything that we could suggest was done for her. Not only did she receive excellent physical care; but she was given materials for knitting; additions to her wardrobe were made, and she was furnished with orthopedic shoes. She remained into the late winter, then went home and had her little boy with her once more.

At this point the secretary of the local agency took over the supervision. Together, we made arrangements for Oscar's continued treatment by a specialist in diseases of the ear, and we provided Mrs. Ungaard with false teeth. I reported developments to her friends, the doctor and his wife, who were eager to help her in any way and who meant to keep in touch with her. The question of bringing over the children from Norway was discussed at length, the final decision being to suggest that she wait a year or more.

The oldest child was a native American and, if he returned before he was twenty-one, would have American citizenship; but the others ran the risk of being deported if they became public charges, which might happen, as their mother was not likely to live many years. In event of her death a good family stood ready to adopt Oscar, the youngest child, who was an unusually attractive child.

Here I closed my record with the understanding that the Family Welfare Society was in charge and would call on me if I should be needed. Three months later, I heard from my colleague in that Society that Mrs. Ungaard had unexpectedly taken her little boy and gone to Norway with the intention of remaining there. I was troubled by this news, since Mrs. Un-

gaard, in her ignorance of her diagnosis, would not understand how to plan for herself. Moreover, when medical care would again be required, her doctor would not have the benefit of her past medical history. Obtaining her address in Norway from one of her friends who was known to the Family Welfare Society, I wrote to Mrs. Ungaard, ostensibly to give her general advice about her health, but really so that if she should be taken ill she might show the letter to her physician who would be able to infer from it what our diagnosis had been.

COMMENT

This case brings up the question of whether or not it is the right of the patient to be told of his diagnosis. If we decide that generally speaking it is the right of the adult patient of full mental powers, we shall probably add that there are exceptions to the rule. In the case of this patient, it seemed to her doctors more than desirable that she should be kept in ignorance — it appeared to be imperative. When she took things into her own hands and quietly left the country for her native Norway, anxiety on the part of her friends was largely because of this ignorance.

As for her action in suddenly breaking away after following advice so faithfully and with such happy results — rather than indicating rebellion or dissatisfaction, it seems to have been an impulsive action prompted by homesickness for her children and in the conviction of complete restoration to health. What was more natural in a devoted mother than to cast everything else to the winds and make up her mind to go at once to her children? She may have deprived her oldest and her youngest child of American citizenship; but it is pleasant to think of her in her native land reunited with her children in the midst of the relatives who had so generously cared for them through the years.

E. W.

Case 22 seems to me to exemplify good and bad medical

work; also good and bad social work. To operate for a toe deformity in a woman who you believe must die before long of cancer of the stomach, does not sound sensible. If there are extenuating facts, they are not in the record. The toe deformity named in the record is one endured permanently by many people, including some physicians, without finding it bothersome enough to demand an operation. It is to be supposed that this patient had already got along with it for many years. Why pick out the period just before an operation for stomach cancer as the right time to attack the toe? It sounds as if two sets of physicians were working independently on different portions of this poor woman's anatomy without knowledge of each other's diagnoses and plans and with scant consideration for her welfare.

Socially the ancient error of deceiving a patient as to her diagnosis seems to have prevailed with the connivance of the social workers. There is no evidence that they argued against this benevolent outrage, though there is evidence that they perceived the error after it was probably too late to correct its bad effects.

The patient trusts us to tell him the truth. We accept the trust by our silence. If we believe in deceiving him under certain circumstances with good motives and with his supposed good in view, he has a right to know of these principles in advance. For they are not what he expects. By saying nothing at all we have implicitly agreed to deal openly with him. That tacit agreement we then proceed to break. That our motives are good does not excuse the bad faith.

R. C. C.

CASE 23

INAKU MOREKYO Age 48 *Single*

Admitted to ward January 27, 1923. Discharged March 7, 1923.

MEDICAL SOCIAL PROBLEM

Carcinoma of stomach; post-operative pneumonia; bronchiectasis; very meagre financial resources; no relatives nor close friends.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Carcinoma of stomach; post-operative pneumonia; bronchiectasis; partial gastrectomy has been performed, the entire lesion having been removed; pathological report: adenocarcinoma.

b. *Prognosis:*
Is believed to be good in view of entire growth having been cut out, if patient can be carried over the effects of pneumonia.

c. *Treatment:*
Prolonged bed care.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient is a native of Japan; has been in the United States twenty-five years; has no relatives here. Brothers and sisters live in Japan. He has worked as butler in clubs and private families; no data on wages obtained, but patient has savings of about $250. No legal settlement. Practically no academic education, although speaks and understands English comparatively well; given a good reputation for sobriety of life by compatriots; courteous, uncomplaining, reserved, self-reliant, but willing to accept advice.

b. *Treatment:*
1. *Plan:* Put patient in a hospital in effort to bring about convalescence.
2. *Results:* Patient enabled to return to work; friendly contact. Later, attempt made to meet medical needs, with probable failure.

c. *Sources of information:*
Friends.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Not needed.
b. *Chronic hospital:* Is available.
c. *Nursing homes:* Too expensive, although suitable.
d. *Convalescent homes:* Not suitable.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* No family; no home; patient has courage and faith in recovery.
b. *Relatives:* No relatives outside of Japan; no help to be expected from them.
c. *Benevolent individual:* No benevolent individual is interested.
d. *Private agencies and institutions* are not available.
e. *Public agencies and institutions* are available.

NARRATIVE

Miss Warren was on friendly terms with this tiny Japanese patient before he had his operation and had talked with him on several occasions. But when she had asked whom she should notify of his condition, she was told that he had no relatives in America and no close friends. He realized the risk involved in the operation, but, in view of the certainty of death without surgical treatment, he preferred to take the chance. Miss Warren was with him just before he went to the operating-room and said to him she would see him as soon as he was out of ether. He looked at her with a quizzical smile, reflecting, evidently, on the slim chance he had to survive. Afterwards, however, she learned that her confident manner strengthened his courage and made him feel that she fully expected him to survive the operation.

The surgeons succeeded in removing the entire growth so that the ultimate prognosis was good; but pneumonia developed and for some time his condition was critical. Then his recovery was retarded by his extreme apathy. Miss Warren did everything she could to encourage him and arouse in him a desire to live; but nothing moved him, and there was no help from outside — no friends to whose affectionate anxiety he might have responded. One evening as Miss Warren was leaving the Hospital, she happened to meet two Japanese in

the street just outside the Hospital. She asked if they were on the way to the Hospital and was told that they were going to call on a fellow lodger, Mr. Morekyo.

Miss Warren turned and went back with them to the Hospital and talked over the situation with them. They disclaimed anything more than casual acquaintance and declared themselves unable to take any responsibility for the patient — especially since he had not, according to the Japanese custom, asked either of them to be present during the operation, in which case the friend performing the service is expected to look after the patient as far as possible. Miss Warren accounted for Mr. Morekyo's seeming negligence by explaining that the Hospital did not allow any non-professional persons to witness an operation. This soothed their feelings and led to a discussion of what could be done for the patient if he recovered. Both men were sure that he had savings, but they had no idea where they might be. They agreed to help Miss Warren and to see her later when the patient's condition was such that they might plan more intelligently for his future care. Then they went in to see Mr. Morekyo.

When Miss Warren told him next morning that she had met the friends who had been in to see him, Mr. Morekyo actually opened his eyes. But he relapsed almost immediately into passivity again. Time went on, and there was no material change in him. Meanwhile, Miss Warren, as a result of her talk with the two friends who had called, received several letters from a Mr. Taimo. The first is quoted here as being indicative of the courtesy of Japan. It was probably typed by himself.

Miss Warren,
Social Service Department, *February* 12, 1923
Mass. Gen'l Hospital, Boston.

Dear Madam: —

I appreciate so much of your sincerity and kindness To Morekyo. Will you kindly understand situation what I stated

to you. It seems to you I am heartless, even to my own countryman, however, I am quite stranger in Boston, I do not acquaint with Japnese people here, except some of students at Harvard and Tech. just happened to go interprete from the statements they made and inquired Morekyo. Under such an environment I personally try to do for him, however, my circumstances would not allow to materially and he will not receive such a way, as to favor. Only thing I can do here after, in case of very serious, I will try best I could for, by referring to the Japanese Society in New York City and consulate where I have quite Friends. But I earnestly hope he will recover within couple of months then I believe he is alright finnancially.

I believe it is best to refer to you about my past career, so as to address to young lady, other wise it quite impolite to do. I am graduate from Chem. Eng. Columbia University 1912 and worked K. H. Brown & Co., Chicago and Phenol Plant of same firm at St. Louis. and other Chicago Chemical firms. and Member of American Chemical Soc. Chicago Section. Member of Y.M.C.A. Boston.

You are doing quite social works and I know of quite bit among Japanese people, so if anything I know of servicible to you I am gladly to do.

Thanking for your esteemed favor,

I am. Yours very truly.

N. Taimo.

Later on, when Mr. Morekyo expressed a wish to know where his bank-book was, Mr. Taimo took his keys to search his rooms. To make sure that the patient understood the situation, the transfer of the keys was made in Miss Warren's presence, the conversation being conducted in English for her benefit. The search produced only one book showing a deposit of $250. Since the patient was determined to apply this to his hospital bill, Miss Warren had still to provide for his convalescence. Mr. Taimo, convinced that Mr. Morekyo must

have more money, again went through his trunk, drawers, and boxes, finding nothing more helpful, however, than the addresses of his relatives in Japan. He reported to Miss Warren as follows:

Miss Warren,
Social Service Department, *February* 19, 1923
Mass. Gen'l. Hospital, Boston, Mass.

My Dear Miss Warren:

I thank you for your esteemed favor time after time. Just yesterday, I have gotten those keys and examined all Morekyo's possession and letters. We found out his native address and those of the relatives in Japan.

All those knew him in years believe he *Must* have more money because he worked steadly years and moreover he is very straight nothing such sportive in characteristics, however, so far as I see in his possession I did not find any bank account beside that of I sent to the hospital, Boston Trust Co's. I am plainly tell you that I did not know his past career, so you know the situation.

Will you do me favor again that you ask him personally, if he has some deposit in the other bank, if so kindly write.

As my part, I am sorry to state that I could not be able to come such a time between 1–2 p.M. because I am now on the job.

Thanking again for your favor,

I am,

Yours very truly,

N. Taimo.

By this time the patient was reduced to a skeleton. Nothing roused him for more than a minute. The doctors having decided that he might gain if he were transferred to another hospital, Miss Warren broached the subject to Mr. Morekyo, endeavoring to induce him to spend his savings on this type of care rather than on the M.G.H. bill which the administration

was ready to remit. He refused vehemently and Miss Warren explained the alternative. He listened attentively while she told him of the care the State provided free to all residents and declared himself ready to go to the State Hospital. Presently he gave in with regard to the bill so far as to pay only part of it, thus leaving himself with some ready cash to meet any needs aside from those met by the State. The hospital to which he went is located in a lovely spot in the country and there was every reason to hope for improvement for Mr. Morekyo from the transfer. Nevertheless, his condition was such when Miss Warren said good-bye to him that she feared she had looked her last upon this most interesting patient.

Not so, however! Within three months he was able to leave the State Hospital. He appeared at the House Social Service at the M.G.H. one day, radiant with joy and health, bringing sixty-nine dollars for the cashier for the balance of his bill and a huge box of choice bonbons for Miss Warren. He said that he could not be sufficiently grateful to the two hospitals for all that had been done for him; and he had nothing else to wish for, since, in the few days he had been in Boston, he had already secured a good job upon which he was to enter within a day or so. Miss Warren spoke at once to the physicians and surgeons who knew him. After examining him carefully, they pronounced his condition wonderful. It was delightful to see their enthusiasm.

For six months thereafter, Mr. Morekyo was not heard from; then he came to Miss Warren to say that he was coughing up blood. Careful examination at the clinic showed nothing wrong; but he was kept under observation for a number of months, during which, though he felt perfectly well, he did no work. There was no evidence of cancer in the lungs, as had been feared at first, nor of tuberculosis. His weight was steady and sufficient for his unusually small stature. He complained that his food did not go down so well as formerly; but there seemed no physical cause for this and the doctors attributed it to nervous anxiety. Miss Warren endeavored to

encourage him and thought he was more cheerful; but he suddenly ceased his visits to the Hospital. After that she did not see him again and was not able to trace him. Perhaps he will come back some day as suddenly as he went!

COMMENT

This case brings out a number of points. In the first place, it is an illustration of the responsibility the social worker has to shoulder when the patient has no relatives or close friends — a grave responsibility when the patient is so ill that he ought not to be troubled by such matters as the arrangement for his after-care, how this is to be financed and so on. Again, the social worker must do alone what commonly friends and relatives do either on their own initiative or at her suggestion — she must attempt to furnish the encouragement usually supplied by the anxiety and affection of outside friends. And she must prevent his lapsing into the condition where continuance in hospital wards seems the line of least resistance.

It illustrates, too, the value of a change in scene in seriously apathetic patients, provided always that the patient's needs are as adequately met in the new as in the old surroundings. In some instances the danger involved in the transfer is too great; but in many others what might seem to an outsider as prostration that would not survive the transfer, proves to be rather a psychical state which responds readily to new stimuli.

It isn't easy to understand the springs of action of anyone; but it is especially difficult to account for the influences affecting one with a foreign background. Speculations as to this patient's disappearance are therefore idle. And yet, how valuable it might be to learn what it was that made him drop out of sight. Did he lose confidence and start for Japan in order to die at home? Or did he regain it so fully that he felt it a waste of time to come to the clinic? This case is an interesting contrast to Case 22, where the doctors feared to tell the patient the truth about her diagnosis and prognosis.

E. W.

This case came near being one of those in which 'the operation was successful, but the patient died,' and the narrative shows how this phrase which has excited so much bitter laughter might after all not be a wholly incorrect statement of the facts. Suppose this patient had stayed on at the Hospital (as without social service he probably would have). There is good reason to believe that, although his cancer had been thoroughly extirpated and his pneumonia healed, his indifference and apathy might have prevented him making any effort to eat. So — many weeks after the operation — with his wound solidly healed and with no disease anywhere in his body, he might have died of starvation. Would it then not be true to say: 'The operation was successful, but the patient died'? One would be forced to admit that the operation was responsible for a bankruptcy of all energies physical and moral, for the destruction of all desire to live and so to eat. But one might add that surgical operations are (or ought to be) done in the expectation that when the surgeon has finished the mechanical part of his job, some further provision will be made, by himself or by his medical or social assistants, to restore the physiological and spiritual relationship between the patient and his world on which his complete restoration depends. He has been severed from many of his roots in the soil of human interests and physiological stimuli. He must be skilfully replanted.

So one might rephrase the old joke: 'The surgeon's operation was successful, but his after-care failed,' and so his patient died.

It is in this process of restoring connection between a sufferer and the vital currents of daily interest — work, enjoyment, affection, and religion (or its equivalent), after disease has cut him off from some or all of them — that social service is sometimes a life-saving effort. Everyone knows that in fighting a disease like tuberculosis, heart disease, or pneumonia one must feed the sufferer and provide for plentiful supply of good water and good air. The life that is in him

must get its energy by transforming the physical energies outside him. Currents of food, air, water must flow through him that his tissues may take up what they need to maintain their own life. But it is just as literally and demonstrably true that in many people the spiritual stimulus necessary to make them use their vital resources must be provided from without or they will die. They will not eat, drink, or breathe properly unless some desire to live, some zest of living, some reason for effort, can be aroused. So a social worker may save the life of a tuberculous patient by arousing in him the courage and interest necessary to energize his physiological machinery. Otherwise he will not take the daily trouble necessary to carry out his dreary medical régime. So much present nursing of effort and patience must be balanced, overbalanced, by a worth-while future and in this he must be made to believe. Chronic invalids are pitifully skeptical, incredulous, of any future happiness or present value. Yet no one can live without belief in some future that is worth the effort to gain it. To nourish this belief is as vitally necessary as to nourish the muscles and the bones.

Moreover, belief in a future that is worth an effort of mastication often depends in sick people on our being able to furnish at once and in advance some specimens of the golden hours which we foretell — as a mining expert might be required to furnish us specimens of the ore in the coal to be mined before we are ready to invest. How can we furnish such specimens? By affectionate (and genuine) interest in him, by the amusements and successes of conversation, by surprises and comforts, by sincere sympathy and admiration. The nurse and the doctor are often immersed in a routine that leaves no time to give the patient this sort of nutrition even when it may be the only thing that will make him chew and swallow. Friends, even close relatives, may be too tired or too bewildered or too unresourceful to do what is needed. Here is the social worker's greatest opportunity — and even she often does not seize it because, like the doctor and the

nurse, she has learned to act as if man could live by bread alone.

In this case fortunately the social worker had a life-saving idea — the idea of change of scene for this poor stranded Asiatic. His energies had come to a standstill. But they were set in motion (apparently) by nothing more exciting than a move to another hospital.

R. C. C.

CASE 24

FEODOR TOBENSKI Age 46 *Single*

Admitted to ward August 3, 1920. Discharged August 25, 1920.

MEDICAL SOCIAL PROBLEM

Adeno-carcinoma of left kidney in a middle-aged man with ample financial resources but with no one to look after him.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
When patient was first in hospital it was starvation phobia. Forced feedings were resorted to at that time. X-ray showed old tuberculous process in lungs. Second diagnosis was adeno-carcinoma of the left kidney with metastasis to liver and spleen, pulsus alternans.

b. *Prognosis:*
First prognosis: Good if treatment is carried out. Second prognosis: Hopeless; patient will probably live only a few months.

c. *Treatment:*
First treatment: Induce patient to eat. Second treatment: Bed care in a chronic hospital.

d. *Additional medical history secured by social worker:*
Patient was in State Hospital in April of this year, going there from another general hospital in Boston where he had been ill with influenza and stomach trouble. State Hospital diagnosis was neuritis of arm. He was discharged from there in

Social
(Family and patient)

a. *Analysis:*
Patient is a Pole and is a Roman Catholic. He has no family; came to the United States about seven years ago, and since then has pursued his trade, baking, at which he has worked since he was fifteen years old. His father and grandfather before him had been the village bakers in their native place in Poland; they had a prosperous business. Patient has earned good wages and has some money saved. Has no legal settlement. Is well educated; speaks German well and English fairly well. Is well acquainted with the history of Europe. Amiable, shy, courageous, and uncomplaining, very religious, strong family feeling, and much pride of race.

b. *Treatment:*
1. *Plan:* First plan encourage patient to eat; connect him with Polish church; secure a more cheerful boarding-house; keep him under close supervision. Second plan: Place patient in chronic hos-

Medical (Patient only)	*Social* (Family and patient)
good condition three weeks after admission. Patient has lost forty pounds this year. In early life lost two brothers by tuberculosis. He has no idiosyncrasy about food; has excellent appetite and is hungry most of the time, but finds that no matter how much he eats he loses weight steadily and is growing weaker. Has constant diarrhea.	pital; assist him in arranging his affairs. 2. *Results:* As outcome of social supervision patient readmitted to ward where second diagnosis was made. Patient admitted to chronic hospital. Legal assistance obtained to make will. Relatives at a distance informed of entire situation. Patient visited until he died.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: (1) Is not needed, as patient is to be under supervision in O.P.D. (2) Not needed, as patient is to enter chronic hospital.	a. *Family and patient:* No family. (1) Patient's coöperation will be hard to win, as he is highly neurotic. (2) Patient's character and disposition insure his coöperation.
b. *Hospitals:* (1) Patient does not need hospital care. (2) Chronic hospital is available.	b. *Relatives:* (1) He has no relatives. (2) He has a cousin in Philadelphia and an aunt in Cincinnati.
c. *Nursing home:* (1) Not considered. (2) Nursing home not as desirable as chronic hospital.	c. *Benevolent individual:* None interested and none needed.
d. *Convalescent home:* (1) Not desirable. (2) Convalescent home not suitable.	d. *Private agencies and institutions:* Several excellent private institutions are available. Legal Aid Society may be called on.
e. *District nurse:* Not needed.	e. *Public agencies and institutions:* (1) Patient may return to State Hospital at any time. (2) Patient has ample funds, therefore is not eligible to State Hospital.

NARRATIVE

One morning the head nurse in a medical ward asked Miss Gordon, the social worker for that ward, to talk with a patient who was ready for discharge and who seemed so alone in the world as to need her help. She spoke to the doctor, who said that, though Mr. Tobenski had been carefully studied, no

physical basis for his complaint could be found. He had odd notions about his food, believing certain things hurt him and preferring to eat nothing but cabbages and turnips; so that a diagnosis of starvation phobia was being made. The only treatment suggested was to break down his prejudice against all food, excepting those two vegetables, and to induce him to try a varied diet.

Thereupon Miss Gordon introduced herself to the patient, who received her with apathetic politeness. He said that he had not been well for some time; that he had had treatment for stomach trouble at another large hospital for acute diseases and at the State Hospital, but, in spite of the good care he had received, he had lost forty pounds during the last year. Two of his brothers having died of tuberculosis, he was mindful of this possibility in his own case. Miss Gordon endeavored to reassure him, advised him to eat more and a greater variety, and not to brood upon the state of his health.

Drawing him out further in conversation, she learned that he had been a baker since the age of fifteen; that he had had work with some regularity, and that he had two hundred dollars in the bank. She proposed finding a suitable room for him in a more cheerful neighborhood and also putting him in touch with the local Polish Roman Catholic Church with which Mr. Tobenski was not acquainted.

Miss Gordon then communicated with a local social agency dealing especially with men, explaining what her patient needed — a room, work, and connection with the church. The Secretary asked that Mr. Tobenski come to see him on his discharge, agreeing to find him a room, to see that he made connections with the church, and to look after him generally. Arrangements were made accordingly; but when, a few days after Mr. Tobenski had left the Hospital, Miss Gordon inquired of the secretary about him, she learned that he had never appeared. Whereupon she wrote to him at his former address, appointing a date for him to come to her office and go with her to the Out-Patient Department Clinic. Then she

called at an address he had given her as that of a friend, only to find that there was no such person at the house.

Mr. Tobenski appeared at the appointed time and Miss Gordon took him to the medical clinic. She had written the State Hospital to inquire about him, meantime, and had received the report that he had been treated for 'neuritis in the arm.' (Which one was not specified.) At the clinic it was found that he had gained six pounds since his discharge a week before. He said that he felt better and complained of no pain. The doctor told him to come again every two weeks, continuing meanwhile to live as he was then living.

For the next two months, Mr. Tobenski reported faithfully at the clinic. His condition did not change materially: he gained a little in weight, but complained of much distress after eating. Miss Gordon having left the Hospital, another social worker took up the case; but, as Miss Warren followed the line of treatment advised by Miss Gordon, there was no change in that respect. However, as no two persons see with the same eyes, let us consider what Miss Warren felt she had to work with and against.

She found Mr. Tobenski a tall, thin man, with long, delicate hands and feet, a narrow, pale face with a sensitive mouth and large, deep-set, dark eyes, and a well-shaped head with thick dark hair sprinkled with grey — a man of sixty, perhaps, plainly of infirm health. He was dressed neatly and in good taste; his bearing was good, his manners easy; he was plainly not a peasant and perhaps was of the upper middle class. He spoke poor English, but excellent German of a kind which indicated a good education — of his use of his native language Miss Warren could not judge. His knowledge of European history, both mediæval and modern, was extensive. He was interested in the World War in a way which indicated that he had not been dependent on newspapers for his opinions. Altogether he gave the impression of having an unusually sound mind which was not at all self-centered.

Learning that he spoke German, Miss Warren made use of

her own knowledge of the language to go over the whole case with him in that tongue. Whereupon she discovered that owing to his imperfect English he had given a false impression in a number of instances. He said that when the doctor in the ward had asked him what foods disagreed with him, he had enumerated several articles, among them baked beans, corn, and tomatoes. Being asked what vegetables he could eat, he had replied cabbage and turnips, to which he had been accustomed since early childhood; *but he had never intended to convey the idea that he limited himself to those two vegetables.* Before he entered the Hospital his appetite had been good, and it was good now. While in the ward, he had not enjoyed his meals, partly because of the hot weather, partly because he had been worried about himself, and partly because he did not care for certain American foods. There were several places near the lodging-house where he lived where he could obtain good food. He was not stinting himself in any way now that he knew he was to eat regardless of discomfort; and since he could get work whenever he wanted it and in the meantime had plenty of cash, he was determined to comply with every suggestion he received at the Hospital.

Still he did not improve. Matters dragged along. Mr. Tobenski's complaints were always the same. He seemed to be fading away beneath Miss Warren's eyes. She could discover no social cause for this and so reported to the doctors. They sent him to the Neurological Clinic, to the Metabolic Clinic — in short, everything one could think of was done. Finally it was decided to send him back to the ward for further study, the admission diagnosis this time being a possible tuberculous bowel trouble or cancer of the thyroid gland. The latter was felt to be the more probable.

Miss Warren arranged for his admission at the former reduced rate, which was given him in view of his dwindled savings and his lack of relatives to help him. He was the most willing and confiding patient imaginable and absolutely obedient. A few days after his admission, his landlady, Mrs. Ran-

dall, visited him and was seen by Miss Warren delivering a letter to him. Mrs. Randall was the first visitor he had had, and Miss Warren asked her to come to her office when she left the ward.

Mrs. Randall reported that she had known Mr. Tobenski for five years and thought highly of him. He had lodged with her some years before when he was in good health and she was shocked by the great change in him. She said that the letter she had given him was from a relative in Philadelphia and enclosed a check for twenty dollars paid on account of an insurance policy which yielded an annual sick-benefit of one hundred dollars and represented six hundred dollars death benefit. The premium on this policy was paid by the relative.

The following day, Mr. Tobenski asked Miss Warren where he could cash his check which he knew was limited to thirty days. The head nurse had already put it in the hospital safe where his bank-book was kept. It was drawn on a Polish bank in Chicago and had three weeks to run. Through Miss Warren it was cashed at the Hospital and the money put in his bank-book.

Miss Warren made a point of seeing Mr. Tobenski daily, the conviction gaining upon her steadily that she was dealing with an unusually intelligent man who had in all essentials a normal outlook. His discomfort was now less than when he had been in the ward four months before; his appetite was good, and he ate whatever was given him. The doctors, meanwhile, were leaving nothing undone. They had abandoned the diagnosis of 'starvation phobia'; but beyond discovering that he had a slight heart trouble which they did not consider the main one, they were unable to make a diagnosis. For three days less than a month, they studied him in the medical ward; a diagnosis of malignant disease in the kidney was finally established and an exploratory operation was advised.

Mr. Tobenski sent for Miss Warren and said to her that he wished to make a will before undergoing the operation; but he did not know how much money he had. Because of failing

eyesight, he had been unable to see the figures in his bank-book for months, and he had had no one whom he could trust to read them to him. At his request, Miss Warren went to the safe and looked at the bank-book. She found that he had $887.42 on deposit besides $100 of War Savings Stamps which were in the book and the $20 in cash from the insurance check.

The will was drawn for him by an attorney from the Legal Aid Society. When it was ready for his signature, Mr. Tobenski asked Miss Warren to read it to him so that he might be sure of what he was signing. He had bequeathed everything he had to his cousin in Philadelphia.

Mr. Tobenski was considerably upset by the prospect of an operation under local anæsthesia, which his heart trouble made necessary, and Miss Warren asked a priest from a Roman Catholic Church near by to make an extra visit, feeling that, since he had been seeing the patient regularly, he could encourage him better than anyone else. But the real need of courage was to be later; for the operation disclosed a hopeless extent of malignant disease, involving kidneys, liver, and spleen. When he returned to the ward, Mr. Tobenski told Miss Warren that he had lain on the operating-table with his eyes covered for what had seemed half an hour, wondering when the surgeons were going to begin. When finally he inquired, he learned that the surgeons had just finished!

Poor Mr. Tobenski! Believing that the surgeons had been able to remove the growth, for the next three weeks he talked constantly with Miss Warren about plans for the future. Christmas came and went, bringing him, among other things, a check for fifty dollars from an aunt in Cincinnati. He began to talk of going out to live with her as soon as he could get strength enough to travel. Meanwhile, he wished to have his eyes attended to, as he could see only large objects and even they looked as if he saw them through a curtain.

No one had the courage to tell him the truth; and yet, without this step having been taken, Miss Warren felt she could make no definite plans for his chronic care, since there was no

one to act for him. The doctors said he would need hospital care until he died — which would mean for from three to five months. Wherefore, Miss Warren visited a hospital for chronic illness and talked over the situation with Sister Murray, the admitting officer. The Sister was deeply interested, especially since Miss Warren emphasized the advantage of her patient's being where he could have all the consolations of his religion for the rest of his life. Sister Murray expected to have a vacancy within a fortnight, and Miss Warren asked her to reserve the place for Mr. Tobenski.

Later that day, she explained to him that the doctors wished him to go to another hospital, told him of the one she had in mind and obtained his consent to go. He still thought he was recovering and evidently looked upon the other hospital as a place for convalescence. Miss Warren was much disturbed. It seemed to her more cruel to wait and let the truth burst upon Mr. Tobenski when he arrived at the other hospital than to break it to him now, and then remove him from a ward with which he had unhappy associations. Finally, two days before he was to be discharged, the surgeon yielded and told him in the presence of Miss Warren that he could not live much longer. He was gentle and considerate, but the shock was severe, as Mr. Tobenski had never doubted but that he was getting well. Slow tears trickled down his hollow cheeks; he groped blindly for Miss Warren and held her hand in silence for a long time.

Two days later he was transferred to the other hospital, where he was in a small, cheerful ward with three other men seriously ill like himself. The spirit of that hospital was different, as a hospital for chronic diseases always differs from one for acute cases. There was no hurry, no complicated routine of visits from doctors, consultants, supervisor of nursing, social workers, and the like. There were gentle little Sisters in grey habits whose hospital was their home and who gave it a homelike atmosphere. Canaries hung here and there, twittering and singing; house-plants bloomed cheerfully

(not exotics forced in hot-houses); and these, with pictures and images of a sacred character and music from the chapel, contributed to make Mr. Tobenski as happy as he could be under the circumstances. In his case, in fact, it may almost be said to have been unqualified happiness. Everybody liked him and tried to do something for him. Sisters from the Polish Catholic Church came regularly to see him; they sang Polish songs and hymns with him; and everyone around him shared his pleasure.

At one time, as he began again to talk of going to Cincinnati to live with his aunt, Miss Warren wrote to her to explain the real situation. Finally, however, he, too, realized it fully. He lost ground slowly, suffering little pain, thanks to opiates. For all that was done for him he was very grateful, and particularly for the privilege of being in a hospital where he had such excellent care and the comforts of his religion.

Mr. Tobenski died nine months after he was first admitted to the ward of the M.G.H. His cousin came on from Philadelphia, and, after services in the church to which the Polish Sisters belonged, took his remains to Philadelphia for burial. The Legal Aid Society assisted the cousin in settling Mr. Tobenski's estate which was sufficient to pay all his debts.

COMMENT

This case is presented as showing that at times it is impossible for the best medical skill to discover what is wrong with a patient until the disease has progressed to a stage where no treatment is possible. This patient was carefully studied during both periods when he was in the wards, yet on the first occasion there was nothing found to indicate what was wrong with him. Without an Out-Patient Department for further observation and without social service to make sure that the trouble was not due to emotional or other psychical causes, the patient might not have returned to the wards.

Although we could not help him to live, at least we helped him to die in peace in a place where he had proper care — a

legitimate function for a hospital to add to its older ones. An outstanding factor in the social treatment was the employment of a foreign language in which both the patient and the social worker conversed easily. Discoveries due to this better medium of intercourse make one wonder how many times foreign patients are misunderstood because they are unable to make their meaning clear in an unfamiliar tongue.

E. W.

This last point should be emphasized. Our medical blunders in this case were due in part to our ignorance of the patient's language and our misunderstanding of what he said. I believe that many of our failures, social as well as medical, are due to the same cause, and that we have not yet learned to distrust ourselves and our powers, medical and social, as deeply as we should when dealing with Jewish, Polish, Italian, Scandinavian, and other foreign patients. The first assumption that we should make in such cases is that we shall probably blunder unless we can get expert help from persons acquainted, not only with the language, but with the traditions, mental habits, and ideals of the patient. *Social work often cannot cross race lines successfully.* Even medical work often fails at the same barrier. Yet we often attribute our failures to the patient's fault or stupidity.

Another glaring lesson in this case is the selfishness of concealing from a patient until the last possible moment the fact that he must face death. We fool ourselves in a case like this into supposing that it is the patient's feelings that we are trying to spare. In reality it is our own. He has to suffer, anyway, but we try to postpone or to push off onto someone else the disagreeable task of telling him what he has a right and a need to know. Social workers should do what they can to wean medical men and nurses from this childish and unkind form of selfishness.

R. C. C.

CASE 25

JULIETTE THIBEAULT Age 19 *Married*

Admitted to ward June 8, 1920. Discharged August 18, 1920.

MEDICAL SOCIAL PROBLEM

Sarcoma of spinal cord in a young wife whose husband has deserted her and who is dependent on her relatives.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Sarcoma of the spinal cord; laminectomy has been performed, but without permanent benefit. Patient is paralyzed from waist down.

b. *Prognosis:*
Patient may live some months, possibly a year.

c. *Treatment:*
Patient will need bed care, preferably in a hospital.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient and husband are of French-Canadian stock; Roman Catholics. Patient married at age of seventeen; husband deserted during first year of marriage and has not been heard from since. Baby died almost at birth. Patient has been dependent on relatives since her health failed. She has not sufficient education to make it possible to find work not too taxing physically. Patient is high-spirited, does not invite sympathy; is rather immature.

b. *Treatment:*
1. *Plan:* Meet patient's needs.
2. *Result:* Patient supervised in slight degree until her death fourteen months later in hospital where social worker placed her.

c. *Sources of information:*
L.M.D.; relatives.

2. THERAPEUTIC ASSETS

Medical

a. *L.M.D.*: Not needed unless patient returns home.

Social

a. *Family and patient:* Husband's whereabouts are unknown. Home

Medical	*Social*
b. *Chronic hospital:* Is available. c. *Nursing home:* Too expensive for more than interim care pending admission to chronic hospital. d. *Convalescent home:* Not suitable. e. *District nurse:* Not needed unless patient returns home.	of patient's sister is not suitable for her to return to. b. *Relatives:* Patient's brothers and sisters will continue to support her. Their love and sympathy will help her. c. *Benevolent individual:* None interested. d. *Private agencies and institutions:* Are available. e. *Public agencies and institutions:* Are available both in Rhode Island and in Massachusetts, but are not needed.

NARRATIVE

JULIETTE THIBEAULT was sent to the M.G.H. by a doctor in Rhode Island, a friend of one of the visiting surgeons of the Hospital, in order that her case might be studied, as he had not been able to help her by treatment. A black-haired, black-eyed young woman, Juliette looked far from ill, although she was paralyzed from the waist down. Her own high hopes and those of her relatives were dashed, however, within a few days of her arrival. For the cause of paralysis had been located; there was a tumor on the spinal cord. Surgical treatment offered the only chance of improvement, and that but a slight one. After careful consideration and discussion of the matter with her sister and two brothers, Juliette decided on the operation. Poor child! It seemed no great risk; to a deserted wife and childless mother, life was not so alluring that she need hesitate to stake it!

The operation resulted in some slight improvement, though less than had been hoped for; and it confirmed the surgeon's fears as to the nature of the tumor. The pathological laboratory reported the diagnosis as sarcoma, that dreaded form of malignant disease which is only a little less prevalent than cancer; wherefore, it was impossible to relieve the paralysis, and Juliette's death was only a matter of time. The surgeon asked social service to plan for her care.

Miss Howard had a long talk with Juliette and her family. The latter were averse to placing Juliette in the hospital for chronic cases in Rhode Island. The alternative was placing her in a Boston hospital, or taking her back home; and it was doubtful if she could have the right care at home. The family decided upon the former plan. They could manage to pay five dollars a week for her. (Their combined income was fifty-seven dollars a week, out of which their widowed mother was to be supported.) Miss Howard told them about Mercy Hospital which would admit the patient and give her the care she needed; they approved of her entering it, although it would mean that she could see her relatives only infrequently. Miss Howard accordingly applied to Mercy Hospital for admission of her patient, whose name was placed on the waiting list, as no vacancies were expected within two months.

This necessitated sending Juliette to a nursing home for the interval; and since the charge there was thirteen dollars more than the five dollars they could pay, it involved raising the money for the deficit. The family visited and approved this home, and Miss Howard, having secured the funds from a private source, transferred her patient to it. The superintendent of the home understood that Juliette would be there only temporarily; and, as it proved, she was admitted to Mercy Hospital at the end of six weeks.

Except for an increasing degree of paralysis, Juliette's condition remained unchanged for just over a year. Then she suddenly developed pneumonia and died within forty-eight hours. The autopsy showed that the process in her spine had been steadily growing ever since her discharge from the M.G.H.

During the year Juliette was at Mercy Hospital, Miss Howard saw her frequently. In spite of being among patients much older than herself, she was contented and even happy. Everyone was kind to her and her relatives visited her regularly, though not so often as they might have done had she been nearer home. As time went on, her mind became affected to a

certain degree, and this probably lessened her appreciation of the situation. There was no clue as to the whereabouts of the missing husband, but, even if there had been, it is doubtful if Miss Howard would have made any attempt to find him, for neither Juliette nor her family had any desire ever to see him again.

COMMENT

Although there are comparatively few cases of malignant disease in persons so young as this girl was, nevertheless they occur often enough to present a problem to the social worker who must provide for their care. As the community's present facilities for persons suffering from malignant disease are in use almost wholly for persons of middle age or beyond it, a young person may spend months dying, surrounded by much older patients. Of course, if there is sufficient means, the social worker may be able to find a private nursing home where this difficulty can be obviated to a certain extent.

If the patient be a man, the social worker has, in most cities, an exceptionally difficult problem in dealing with cases of this sort. There seems to have been a general feeling on the part of benefactors that endowed hospitals charging a merely nominal sum should be limited to the female sex; perhaps they have proceeded on the theory that men are the more able to provide for themselves. In any event, it makes it difficult to get care for men afflicted in this manner, and the social worker must bring before the community the fact that more and more cases of malignant disease will come to light in groups which heretofore have been considered practically immune. Not that it is the belief of the medical profession that malignant diseases are on the increase; but cases are now being correctly diagnosed as never before, so that figures apparently point to an increase in the disease.

As to the deserting husband in this case, Miss Howard would seem to be justified in having ignored him. Her patient

was content without him. Miss Howard felt it right to think first of her peace of mind, and relegate to second place the young man's soul and the benefit it might have received had he been haled back to face his responsibilities.

E. W.

CASE 26

MINNIE LOURIE Age 41 *Married*

Admitted to ward July 6, 1920. Discharged August 31, 1920.

MEDICAL SOCIAL PROBLEM

Question of metastatic carcinoma in a woman who has young children and who is separated from her husband; dependent on brother.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Lies between malignant disease of the lung and chronic non-tubercular infection of the lung. Severe cough accompanied by hemorrhages is present. There is a history of removal of ovarian tumor about six years ago; no pathological report on nature of tumor is available. Patient has recently spent six months in a sanatorium for pulmonary tuberculosis.

b. *Prognosis:*
Is doubtful.

c. *Treatment:*
Patient requires prolonged bed care because any activity brings on cough and hemorrhages.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient and husband both Polish Jews. Patient and husband were married in Poland and came to the United States soon after. Their four children were born in different Eastern cities, as family has moved about a good deal, owing to husband's work; considerable friction between patient and husband followed by latter's deserting about five years ago. Husband now contributes about $20 a week to support of family. Patient has earned about $30 a week. Her brother aids whenever necessary. Husband's health has always been good. Of the two surviving children the ten-year-old son needs surgical treatment for inguinal hernia; the fourteen-year-old daughter is well except for frequent attacks of tonsillitis; she needs glasses. Patient and husband have imperfect command of written English, but speak it very well. They are well educated, having a considerable de-

Medical (Patient only)	*Social* (Family and patient)
	gree of culture; are much above the average Polish Jew immigrant. Anna is in the first year of high school; is very good scholar. Edwin is in the sixth grade of the grammar school and is also a clever child. Husband has a small shop in a large town in a northern New England State. Patient is head of a department in a large retail mercantile concern in Boston. Husband has quick, impatient temper; is headstrong, not domestic in tastes and habits; is careless about money matters; apparently has no more serious faults. He is fond of his children, and underneath his resentment at patient smoulders a pretty warm feeling for her which is manifested to some degree through jealousy of her love for the children. Patient is an impulsive, warm-hearted, generous woman, good-natured, and considerable sense of humor, an entertaining talker and excellent saleswoman. Intelligent mother whose one interest in life is her children, very sensible in her ambitions for them. Not interested in men; has an irreproachable reputation. Fond of husband in spite of indignation at his treatment of her and the children. Anna and Edwin are well-behaved, although prone to bickering in a childish way. Both are affectionate, obedient, good-natured, ambitious, and studious.
	b. *Treatment:*
	1. *Plan:* To meet patient's needs. Attempt reconciliation of patient and husband.

Medical
(Patient only)

Social
(Family and patient)

Guide patient in planning for children.

2. *Result:* Supervision of patient until her death a year later. Medical treatment secured for children and supervision given them in a lesser degree for a year and a half after patient's death. Implications of patient's illness explained to her brother and husband, bringing about a better understanding by the latter of patient's behavior toward him, although this was not accomplished until after she died. Considerable influence exerted in awakening relatives to a sense of responsibility for children's future. Children's love and respect for patient strengthened.

c. *Sources of information:*
Relatives; other medical agencies.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Choice of L.M.D. is with social worker.
b. *Chronic hospital:* Is available.
c. *Nursing home:* Private nursing homes of excellent type are available.
d. *Convalescent home:* Not needed.
e. *District Nurse:* Not needed.

Social

a. *Family and patient:* Probably no help may be expected within the family circle, as children are too young and husband is alienated. Patient is sensible, complies readily with advice of physicians, confident of getting on well if obedient, but mindful of danger from hemorrhage. Is neither fretful nor depressed. There is no home.
b. *Relatives:* Patient's brother, a prosperous merchant, devoted to her and her children, will aid in every way. Patient's aunt and husband's cousins stand ready to do

Medical *Social*

anything they can; all are well-to-do and are very fond of patient with whom they side in difficulty with husband.

c. No *benevolent individual* is interested.

d. Suitable *private agencies and institutions* for care of patient and children are available.

e. *Public institutions and agencies:* Are not needed.

NARRATIVE

MRS. LOURIE was sent, on the diagnosis of a physician of high standing, to an excellent private sanatorium for the treatment of tuberculosis; but after six months during which her pulmonary condition grew steadily worse, the physician in charge of the sanatorium decided that the trouble was not tuberculosis, but a tumor in the lung. Wherefore he persuaded her to enter the M.G.H. for diagnosis, agreeing to take her back if further sanatorium care was recommended. At the M.G.H., her case was studied for six weeks before the physicians could make a diagnosis, which was tentative, although they held that the preponderance of evidence was for malignant disease.

During those six weeks, I had become acquainted with Mrs. Lourie, a brown-haired, grey-eyed, plump woman of medium height, who did not look in the least ill, and by the time the physicians asked me to undertake to arrange suitable care for her after her discharge from the Hospital, I had a general idea of her circumstances. Also, by this time, Mrs. Lourie was ready to accept my aid in planning for her future and spoke to me frankly of her past life.

Her marriage, one of inclination on both sides, had been unhappy almost from the beginning, owing, she declared, to Mr. Lourie's hasty temper, his impatience with the restraints of family life, and his carelessness about money. If he earned enough for the needs of his family, well and good; if he did

not, he expected his wife to ask for 'gifts' from her brother. The latter had always been more than ready to help; but the situation was intolerable to Mrs. Lourie who had earned her own living before marriage. Matters went from bad to worse; the bickering and quarrelling became almost incessant and even degenerated on one occasion into a scuffle in which her husband knocked her down. He was ashamed, said he hadn't meant to, and for a little behaved much better. Soon, however, he resumed his exasperating habits and finally he left home and was not heard of for some time.

Mrs. Lourie secured a position in a large department store and with help from her brother got on very well. After a little her husband began to send her money, which she accepted for the support of the two children still living, the two younger ones having died as infants of what had seemed trifling ailments. For a number of years she continued to get on comfortably. Then her health began to fail. She went from one doctor to another without benefit, until at length a hemorrhage from the lungs led her to consult a specialist who said she had tuberculosis. He considered her prognosis good, however, if she would take sanatorium treatment.

She followed his advice. Her children were left as boarders at the home of a friend with whom she had formerly boarded, while her brother, who lived in Hartford, Connecticut, kept fairly close watch of them and often had them stay with him at his home. She had sold her furniture to raise money to pay, in part at least, for her treatment; but the three hundred dollars she realized did not last more than three months, and her faithful brother paid the balance. Her position had been held for her since her admission to the sanatorium; but now that she could not hope to go back, she would have to rely wholly on her brother.

When I suggested that we consult her brother before making plans for the coming winter, Mrs. Lourie agreed readily, though I could see that she hardly understood the necessity. She was unaware of the significance of the doctor's diagnosis

should it prove to be malignant disease. Later I discovered that she thought the word applied to some pulmonary disease, and had no idea that it referred to cancer, with which she had the usual dread familiarity.

In response to a letter from me giving no medical data except that Mrs. Lourie's condition was serious and was not realized by her, her brother, Joseph Secovsky, came to Boston to see me. A man of charming presence, giving the impression of fine character, his means were so ample that he instructed me to find a suitable home for Mrs. Lourie regardless of expense. He confirmed practically everything his sister had said with regard to her husband. As it was impossible for him to remain in Boston long enough to visit any of the private nursing homes of which I spoke to him, he bade me make the decision for him — whatever met my approval would be satisfactory to him.

I installed Mrs. Lourie in a pleasant room in an excellent private nursing home which admitted only patients who were not expected to die. The Superintendent understood what Mrs. Lourie's prognosis might be, but was willing to take her. Thus she had the advantage of being in a more cheerful atmosphere than usually prevails in places caring for those in more serious condition. The rate was twenty-five dollars a week, not including medical care or medical supplies. A physician would be called in if necessary.

For a month I kept in close touch with the situation. Then, as Mrs. Lourie was getting on comfortably, was not troubled by any cough or hemorrhage, and would be seen by me whenever I found it necessary to visit other patients in the home, I closed my case record, knowing, however, that later on I might have to reopen it. Nearly three months elapsed before I was needed.

Mrs. Lourie lost the sight of one eye. An eminent specialist saw her and recommended that she be admitted to a hospital for observation. Here the verdict was that the trouble was due to a tumor behind the eye. The doctors advised me that

an operation for the removal of the eye might have to be performed later if the pain became unbearable. Loss of sight in the other eye was also to be apprehended.

Although unaware of all this, Mrs. Lourie was ill at ease and threatened to commit suicide if she became blind — she did not dream that the diagnosis signified something yet more serious. She was worried about her children, and asked me how she could get sole guardianship, since she could not trust her husband's intentions toward them. I explained that there were two possible procedures; by mutual consent of the parents or by legal action to prove the unfitness of either to be guardian. As neither course seemed possible just then, the question was dropped for the time being. Mrs. Lourie returned to the nursing home temporarily, the Superintendent having become so fond of her that an exception was made in her favor.

Mrs. Lourie grew increasingly restive and uneasy because she could not find out what she was to expect in the future. And whatever was to happen to her, her children's future must be safeguarded. She would work herself into a frenzy dwelling on various instances of her husband's exasperating behavior, of the neglect, even abuse she had suffered from him and of the scandalous stories he had told her relatives about her. She complained that the doctors would not give her any information, and insisted upon my explaining to her the meaning of medical terms she had been given at the hospitals.

I thought she was right in demanding knowledge of her probable future. Then, too, I realized that with the tumor near the brain, the probability was that later on there might be a mental condition which would make it impossible for her to act as wisely as she might at this time. There was no physician in charge at the moment, and I answered her questions as well as I could. I explained in guarded terms how a malignant tumor differs from a harmless one, the method of its transplantation through the body (I used the simile of a

brook carrying seeds which catch on the banks here and there, growing into plants like the parent plant); and the possibility that death would be the result of the process. Mrs. Lourie, realizing the seriousness of it all, agreed upon consulting her brother as to the next step. It was more difficult, however, to persuade her to give up the idea of calling in a chiropractitioner of whom she had heard.

Mr. Secovsky came to Boston to talk over the situation. I advised seeking admission for his sister to an excellent hospital for chronic cases where the charge would be the same, but would include medical attention, now becoming increasingly necessary. He saw the hospital and approved of it. He said he would always watch over the children, the more eagerly because he and his wife had none of their own. In case of his sister's death, even if the father secured sole guardianship, he felt there was no cause for alarm, as Mr. Lourie was not so bad as his wife thought him. However, he wished me to reassure Mrs. Lourie as to this matter so that she would not be disturbed. Feeling that he was perhaps inclined to take the future of the children too lightly, I endeavored to make him realize the necessity for wise discipline now if they were to make the most of their natural gifts. I dwelt, too, on the danger of their growing away from their relatives and from each other. (By now they were in separate homes, as they had quarrelled so constantly that their first hostess refused to keep both.) Mr. Secovsky took all this in so kindly a spirit that I felt he would do the right thing by Anna and Edwin.

Within a few weeks Mrs. Lourie was again in the hospital where she had gone for observation, for her diseased eye had to be removed. She was losing weight rapidly, though she was still far from thin; but in spite of unfavorable symptoms she was quite sure that when her eye was taken out, together with a small part of the tumor behind it, she would improve rapidly. And she began to make plans for legal action to secure sole guardianship of the children, repeating her com-

plaints against her husband over and over, with a bitterness that was painful to witness. She looked forward, too, to returning a little later to the nursing home, though meantime she was willing to go to the hospital for chronic illness, on the recommendation of the doctor who had performed the operation.

She was unaware of the real reason for this change from the nursing home, and I became uneasy, knowing it would be a real shock to her to learn on arrival what kind of hospital it was. I foresaw her distress when she began to wonder why no treatment was given her, no glass eye made. Wherefore, when she asked me to talk freely with a cousin of her husband's, I seized the opportunity of impressing upon Mrs. Cohen, and through her, upon the other relatives, the critical stage of Mrs. Lourie's disease. Mrs. Cohen had already learned from the doctor that the pathological laboratory had reported that the tumor was cancer, so she grasped the situation clearly.

When the time came for Mrs. Lourie to go to the hospital, I accompanied her in the ambulance, which mode of travel seemed to the doctors safest for her. Hardly were we started on the long drive than she asked me if I knew Dr. Richard Cabot. I knew him, of course. Did I follow his precepts? Wasn't he the head of the department to which I belonged? Having agreed to all her questions, I was cornered when she faced me and declared: 'Yesterday I read in the paper that Dr. Cabot believes that patients have a right to know the truth about themselves if they wish. I want to know the truth, and if you live up to his principles, you must tell me.'

I was somewhat at a loss in that I had explained malignant disease to her; but it soon became clear that malignant disease was one thing to her and cancer a wholly different thing. It was hard to tell her all; but I have always been glad that I did so, for she knew me, and, as she said, heard it from me more easily than from one who took no particular interest in her. She took it quietly, said she wished to make all her plans while she was able to do so and talked sensibly about her

children. Then as it came over her again that it was her husband's behavior that was at the root of all her anxiety about Anna and Edwin, she became so excited that it was some time before she could be calmed down. When we arrived, however, she was her usual cheery self.

Months passed. The progress of the disease was steady, but so slow that Mrs. Lourie began to have hope of ultimate recovery and begged to be allowed to go back to the nursing home, promising to return if she proved to require too much care there. There was no objection to this and she went back. Here the medical supervision was slight. A standing order for opiates was given and the nurse and I were told to use our own judgment in regard to her daily activities. We let her do as she liked, that she might be as happy as possible, her relatives agreeing with this plan.

Finally a terrible hemorrhage occurred after she had spent two days in bed. This relieved the pressure in the throat and stomach, and Mrs. Lourie would have been distinctly better but for increasing mental symptoms. A physician was called in, but she clamored for specialists. She began to make trouble for other patients in the house, and presently reached a stage where even the Superintendent's fondness for her could not make her feel that she could keep her longer. I could not get her back into the hospital from which she had come because there was no vacancy, so I moved her to another nursing home. Here, five weeks later, she died.

The last two months of Mrs. Lourie's life were very difficult for everyone because the disease had attacked her brain. Her children were especially distressed until I explained to them as well as I could what was happening and tried to help them meet the situation. Poor little things! A dying mother and a father who lived in another State and never saw them — what wonder that, though they had affectionate relatives at hand, they were terrified and distressed!

Their mother had been planning for them up to the last, insisting anxiously that they have the operations advised by the

M.G.H. doctors to whose clinics I had taken them. I wrote to their father explaining the situation from my point of view and asked him to write me or call at the office to discuss plans for them. I received no answer, but, as the letter was not returned, I assumed that he received it. Mrs. Lourie's brother, however, who had taken the children to his home after her death, asked me to arrange for any medical or surgical treatment that might be needed for them. They came in, and Anna had her tonsils removed and was fitted to glasses and Edwin had his rupture attended to. In the course of correspondence between us, I took occasion to write a letter to each child dwelling upon the anxious thought their mother had given them, on her ambition and high ideals for them, and on my own certainty that they would do their utmost to become the man and the woman she wanted them to be.

Finally one day, when the children came to the clinic for a follow-up visit, to my surprise, their father was with them. He made a better impression than I should have expected. I was not, I think, prejudiced; still there was a record of selfishness and indifference on his part, even if I did not believe more serious charges made against him. A tall, heavily built man with rather a kindly face, he was intelligent and well-mannered and seemed concerned for the welfare of the children.

We had a long talk together. Mr. Lourie began by saying that, while he did not attempt to defend himself, he wished to tell me something of the trouble between himself and his wife. From the beginning of their married life, Mrs. Lourie had had what might be called 'spells of being unable to tell the truth.' She would relate to her husband things that had happened to her or the children during the day which a responsible person would have known were not credible. He would learn from a servant or someone else that no such thing had happened; or he could prove by the children that they had not been hurt and bruised by terrible falls. Mr. Lourie owned that he had a hasty temper and was inclined to resent any questioning as to

his behavior, his use of time and money, his occasional lack of steady income. Becoming increasingly unhappy at home, he had absented himself the more frequently. Returning he found the home less and less comfortable until finally he left permanently, although he had never meant to abandon the financial support of the family according to his means.

Since Mrs. Lourie's death, he had come to believe that the tumor in her head might have affected her mind for many years back, and to realize that her peculiar behavior could be thus accounted for. Realizing how grieved he must be at his own lack of understanding of her, I tried to suggest that possibly he might make amends for the suffering he had caused her by devoting himself to the children. He declared his intention of looking out for Anna and Edwin. He could not now establish a home for them, but would leave them for the present with the families with whom their mother had had them boarded and where he felt they had excellent care. His analysis of the children tallied with my own observation of them; and after this interview, I felt far more assured of their future.

During the next three years I saw them off and on; sometimes they needed medical attention; sometimes they just dropped in to see me. Their progress delighted me. They did well in school; their relations to each other were satisfactory; they seemed to have a sensible outlook; and they gave promise of being all that their mother could have hoped for them. They spoke often of her and loved to hear pleasant things about her. They remained boarding with the same families — a wise arrangement, apparently, as Mr. Lourie had become a travelling salesman and could be with them occasionally and supervise them without interfering with the routine which was well established and brought excellent results.

COMMENT

It may seem that this is the record of medical follow-up more preponderatingly than of social work. The latter was there, however, only of a sort which is difficult to evaluate.

To what extent did the social worker influence the patient against undertaking ineffective legal action? How much did her opinion influence relatives, especially the patient's brother? Was it, perhaps, the reputation given her by his relatives which finally led Mr. Lourie to come to see her without fear or antagonism? How much is it worth to society to know that an institution has functions outside its walls which enable persons to feel that a sick relative will be watched over with personal concern in their absence? Finally, what did it mean to the dying mother to have someone who could advise her as well as sympathize with her, and who could reënforce her efforts for her dependent children?

One aspect of the case is not unusual — the history of early mental symptoms in a patient who finally dies, with a tumor on or near the brain as a factor in the last sickness. It occurs often enough to make it worth while to consider it in certain obscure cases. If this were even suspected, how would the social aspect of such cases be affected? Is it too much to hope that many an exasperated husband or wife would be more forbearing and considerate if told that certain disagreeable habits of the spouse were due to such a cause? In this particular case, one deplores the lack of an autopsy which religious scruples forbade. This might have settled the question of the location of the primary tumor. Finally, one learns from this history that the clearest vernacular must be used if one wishes to give the patient genuine information of his condition.

E. W.

CASE 27

TITO FERRARI Age 31 *Married*

Admitted to Orthopedic Clinic, March 14, 1922. Referred to Social Service, July 18, 1922.

MEDICAL SOCIAL PROBLEM

Amputation of leg for sarcoma; inability of bread-winner to work; public aid necessary.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Osteogenic sarcoma.

b. *Prognosis:*
Fairly good.

c. *Treatment:*
Patient should have an artificial leg in about three months and meantime should continue to wear a peg-leg.

d. *Additional medical history secured by social worker:*
None.

Social
(Patient and family)

a. *Analysis:*
Patient and wife are natives of Italy; children are American born. They are Roman Catholics. Patient and wife have been in Boston for about twelve years. Patient has worked in a factory as a laborer for eight years earning about $30 a week. Patient is poorly educated, but he speaks English fluently, although imperfectly. Patient is an earnest, reliable man who is anxious to resume his responsibility for support of family. No other information available on wife and children, as work with them was done by another agency whose full data were not necessary to M.G.H. record.

b. *Treatment:*
Patient encouraged and referred to State Department of Education for vocational training and for aid in paying for artificial limb. Balance of price of leg secured from private fund in Hospital. Leg ordered. Conferences with Family Welfare Soci-

Medical (Patient only)	*Social* (Family and patient)
	ety and Overseer of Public Welfare. Reports to Department of Public Welfare. Employer written to. Patient supervised until leg is satisfactorily adjusted. c. *Sources of information:* Hospital where operation was performed; district nurse; social agencies.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Not needed. b. *Hospitals:* Treatment at home and at Out-Patient Department Clinic is suitable. c. *Nursing homes:* Not needed. d. *Convalescent homes:* } Not needed. e. *District nurse:* }	a. *Family and patient:* Patient's desire to return to work is valuable. b. *Relatives:* None who can help. c. *Benevolent individual:* None is interested. d. } *Public and private agencies and in-* e. } *stitutions:* Are all available.

NARRATIVE

One July morning, a social worker found in her clinic a heavily built Italian who was volubly explaining his difficulties to a nurse who wasn't able to cope with the situation. The social worker, Miss Moore, learned from Tito Ferrari, who spoke English easily, though imperfectly, that he was looking for a doctor who had promised to help him. Four months earlier, he had been sent to the clinic at the M.G.H. from a hospital where his leg had been amputated, the surgeon there having told him that an artificial leg could be fitted to him. Upon reporting, he had been examined and told to return in three months to be fitted for a permanent limb, continuing meantime to wear the peg-leg. The three months were more than up, but, although he had visited the clinic several times, Tito had not been able to find the doctor who had promised him the new leg. What was he to do? He was anxious to go to work, but he couldn't do anything without the leg.

Having found that Tito's statements were correct, Miss Moore arranged for his examination by another doctor, the one he sought so anxiously not being then on service. The former advised having the permanent leg fitted at once and Miss Moore set about getting it. Talking over the situation with Tito, she found that his only income at present was sixteen dollars a week which he was receiving from the Overseer of Public Welfare, on which sum he and his wife and five children — ranging from eighteen months to eight years — had to subsist. He had formerly worked in a factory, earning good wages, and he said that when he got to work again he would pay at least a part of the cost of the limb. Miss Moore, however, thought it best not to burden him by any definite promise, trusting to his voluntary action when the time came; she therefore explained to him that she could probably get the leg without expense to him. And she promised to do this as quickly as possible.

The Overseer confirmed Tito's statement and reported that he was confining his activities to the weekly payment, the Family Welfare Society carrying on the social case work. Accordingly, Miss Moore suggested to the latter society joint action for Tito, and together they agreed to refer him to the Rehabilitation Section of the State Department of Education for vocational training and for financial assistance in obtaining the artificial leg. (Fifty of the one hundred dollars necessary for this leg would be given out of a special fund controlled by the M.G.H.)

During the six weeks which elapsed while this plan was being put into execution, Tito grew very restless. He couldn't understand the delay and began to lose courage. Miss Moore did her best to make him feel that he was not forgotten and assured him that it ought not to be long before he might get to work. She explained that it required some time to have the leg made, as the manufacturers were very busy and were at a distance from the city. Believing that he would not understand the slow process of financing the purchase, she did not

tell him the details. Neither did she tell him of an unsuccessful attempt that had been made to win the interest of his former employer.

Months went by, and still, for one reason and another, all unavoidable, the leg was not ready. And when Tito finally got it and it was pronounced satisfactory by the doctor, over a year had passed since the amputation of his leg! Three months later, it became apparent that the hospital social worker was no longer needed and she withdrew, leaving the Family Welfare Society and the State Department of Education to see that Tito became fit for work and was provided with a suitable job.

About a year later, Miss Moore learned from another social worker who knew him that Tito was suffering from recurrence of the malignant disease, this time in the lungs. His condition was, therefore, hopeless. He had never been able to work and had gotten so little use of the leg that the money had been practically wasted. The family had received aid regularly and would continue to do so, although from a different department, as Mrs. Ferrari was now eligible for Mothers' Aid.

COMMENT

This case illustrates what can happen to a patient who falls into the busy stream of the clinic without being referred to the social worker who can help him get what he has come for. In this case the patient was not known to the Social Service Department in either hospital until he himself stumbled upon it. In time, it may be hoped that reference of such cases to a social worker may become automatic.

Apparently in this case there was no attention paid to the ultimate prognosis, and the social worker was unable to obtain from the surgeons any definite statement as to the possible recurrence of the malignant disease, nor, in view of its possible extension to other organs, as to the probability that the patient would be unable to profit by the expenditure for the leg.

Five months and two days elapsed between the date when the doctor declared the patient ready for the artificial leg and the date of its delivery to the patient, and when the social worker withdrew, three months later, although fifteen months had elapsed since the original amputation, the patient was still to be trained for his new work. During all this time public aid amounting to at least sixteen dollars a week had been given and private aid of one hundred dollars for the leg, in addition to the indirect cost of supervision. Incalculable harm, moreover, had been done to the morale of the patient.

Had the connection with Social Service been made at the time of the amputation, plans could have been instituted at once so that by the time the stump was in condition to have a permanent leg fitted — assuming that the chance of recurrence had been small — the leg would have been ready, and the re-education could have begun. The second opportunity was lost at the time when the surgeon told the patient that the leg could be fitted in three months. This period of necessary delay could have been well utilized by the hospital social worker in securing the leg and preparing the patient to begin upon vocational training. It is not clear whether there was undue delay in the matters of raising money and making the leg; but it seems probable that there was a margin which might have been eliminated had there been time to plan without the element of emergency.

E. W.

'Rotating service' is the name of an arrangement whereby a group of physicians and surgeons are on duty daily at the Hospital for some fraction of each year, usually four months or six months, and then are replaced by another similar group. Such an arrangement helps to keep the doctors from getting 'stale' or overworked, and allows them time to earn their living unburdened during part of the year by the heavy duties of a hospital service.

But obviously an entire change of the responsible medical

personnel twice or thrice a year makes it difficult or impossible to transfer from one set of physicians to their successors all the important details affecting the lives of patients who 'carry over' from one service to the next. This difficulty is met in part by the longer service of the internes, young graduate physicians who ordinarily spend a year or two in hospital work before beginning to earn their living in practice. But internes also shift rapidly from ward to ward. The same is true of nurses. In view of this constant shifting of office among those in charge of patients in a hospital, serious mistakes like that recorded in this case are certain to happen. One doctor promises a wooden leg, goes off duty, and forgets all about it. His successor, of course, knows nothing and does nothing about it. The patient, especially if he is a foreigner, suffers from the result of our bad organization. And the more thorough and individualized our treatment is, the oftener these abominable mistakes happen because there are more details and more variety of service to be attended to.

The remedy is to place squarely and securely upon the shoulders of the permanent hospital officials the responsibility for all the important long-time tasks of diagnosis and of treatment, the responsibility, if not the performance in most cases. Such permanent members of the hospital staff are the Superintendent and his assistants and the social workers. The Superintendent and his assistants are at present burdened in most hospitals with such a multitude of financial and executive duties not directly concerned with the care of patients that they are not free to attend to matters of diagnosis or of treatment.

There remain the social workers, who, of course, are not fitted themselves to carry out diagnosis or treatment except in the social field. But they can see to it that medical and surgical energies are called into action for the benefit of those patients whose troubles they may happen to be acquainted with. This does not mean all the patients who need such help. Far from it. It means certain groups of sufferers such as the

tuberculous, the diabetic, and all those whom the hospital authorities wish to get out of the Hospital because there is no more to be done for them there, or because their beds are needed for more acute or pressing cases. In this last group come the cases described in this section.

But there are many others, especially in the surgical wards, whom the social worker meets only by chance (as in the last case) or not at all. In this last case her efforts were nearly useless because of the neglect of others previously and simultaneously concerned in his welfare. The poor patient had too many cooks busy or idle about his broth.

R. C. C.

MISCELLANEOUS

(Ten cases)

NOTE

Case 28. *Henry Brotherton:* æt. 13.
Infectious arthritis with chronic tonsillitis; poor adjustment in home and school.

Case 29. *Bessie Shapiro:* æt. 21.
Psoriasis; deep mental depression; unfavorable home conditions.

Case 30. *Anna Hopkins:* æt. 36.
Fibroids of uterus; mental disease; broken home; dependence on relatives.

Case 31. *Dominic Petronio:* æt. 37.
Lobar pneumonia; no financial resources; public aid.

Case 32. *Giovanni Tremuri:* æt. 34.
Exophthalmic goitre; insufficient income.

Case 33. *Oscar Anderson:* æt. 62.
Fracture of femur and both bones of right forearm; no relatives or friends, no home, no money; workmen's compensation.

Case 34. *Marietta Simpson:* æt. 71.
Fractured femur; old age without financial resources; institutional care.

Case 35. *Bridget Grogan:* æt. 24.
Attempted suicide; widowhood; no home.

Case 36. *Mabel Wadsworth:* æt. 20.
Visceroptosis; feeble-mindedness; question of psychasthenia; suicidal ideas; broken home; successful readjustment in community.

Case 37. *Margaret Kelley:* æt. 75.
Arterio-sclerosis; dependent old age.

NOTE ON MISCELLANEOUS GROUP

This miscellaneous medical group offers opportunity for presenting various principles of social treatment which have a general application.

1. The necessity for quick action is shown in cases where the medical problem is such that, except for the social side, the hospital's connection with the case would terminate with the decision of the physician that the patient does not need treatment in the wards or clinics. To get him out of the hospital at once then calls for speed, as well as skill in making suitable provision for his needs.

2. The matter of *responsibility to another institution* for patients placed there is illustrated.

3. The difficult problem of *compensation for injuries* received at work is exemplified.

4. Also the difficulties involved in treating a patient through correspondence.

5. Those of readjusting the feeble-minded or mentally abnormal patient who has the further handicap of physical disease. All these demand broad equipment and training for the social worker.

In their interest in the medical aspects of certain cases, social workers are sometimes prone to overlook the wider social and spiritual implications. It is poor social work, for example, to ignore the social prognosis of a feeble-minded child of equally defective parents, and to employ for it the sort of treatment whose value depends upon intelligent care after the patient returns home — if return he must. If wise use is to be made of the facilities offered by medical and social agencies, the importance of heeding both the medical and social prognosis cannot be overemphasized. Such organizations as children's agencies, sanitoria, hospitals for heart disease, etc., are justified in their rule of refusing to bestow their limited care upon individuals who cannot, we believe, be restored to normal activities. For those so unfortunate as to be excluded, the social worker must provide the best substitute she can devise. Often she can do no more than establish and maintain a friendly relationship with her patient and with his family or friends.

This matter of friendliness is important in all medical-social work. A social worker who is disliked by patients and their families had better turn to other work: she cannot help patients who dislike or fear her or whom her presence irritates. She must, however, maintain her professional relation towards the patient; whatever she does for him should be in conformity with her professional standards. She must always be on the alert to seize any opportunity for social treatment which may present itself, and must guard against allowing her contact with her patient and his family to become too 'personal,' lest she forfeit her freedom of action and professional influence which must always be exerted against wrongdoing.

From whatever angle one looks at social case work, one returns to the same beliefs as to the fundamental principles upon which it must be based if it is really to help. It must be based upon the needs of the patient, of his family and of society. The patient is not to be treated as an isolated individual but as one who is imbedded in the social group.

CASE 28

HENRY BROTHERTON Age 13 *Single*

Admitted to ward November 28, 1923. Discharged December 13, 1923.

MEDICAL SOCIAL PROBLEM

Infectious arthritis and chronic tonsillitis; difficulties at home and in school because of frequent illnesses.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*

Infectious arthritis; chronic tonsillitis. Patient has had frequent sore throat with swollen glands in neck; had a tonsillectomy in 1914; as infant, much retarded in walking, supposedly owing to fall on his head; was very ill for some time after; always 'nervous'; has had measles and pneumonia. Present illness began in left knee joint one month prior to admission; hip now involved. X-rays show no definite variation from normal in knee, hip, heart, and gastro-intestinal tract. No evidence of syphilis.

b. *Prognosis:*

Is good, since focus of infection has been located in tonsils.

c. *Treatment:*

Tonsillectomy and hospital care until acute stage is past. After that, careful attention to diet, which should be of the most nourishing sort. No school for several months. As much fresh air as possible.

d. *Additional medical history secured by social worker:*

Patient has been in a boarding-

Social
(Family and patient)

a. *Analysis:*

Father and mother both native Americans of Anglo-Irish stock; Presbyterians. Father has been dead some six years. Mother has since moved the family to Boston from the small town where all the five children were born; took this step because of better educational facilities and in order to be near paternal relatives. Family life has been uneventful with exception of some trouble with patient, who has been hard to control in matter of school attendance because of discouragement. Ralph, who is two years younger, is in same grade in grammar school, which has made patient unhappy. Paternal relatives prefer Ralph to patient, whom they have tried to urge to greater efforts at school by contrasting his career with Ralph's. Their lack of sympathy for his poor health has been the occasion of dissension in the family. Father left mother a fairly comfortable income, which, together with salaries of sister and oldest brother, renders family comfort-

Medical (Patient only)	*Social* (Family and patient)
school where diet was meagre and dormitories were cold; his general condition deteriorated seriously during two and a half months' residence there.	able. Rent is $40 a month. Mother has a legal settlement in Boston. Health of entire group with exception of patient is excellent. Father died of acute septicemia following an infected wound on hand. Father was a graduate of an excellent college. Mother has a good education. The only sister, aged twenty, is a graduate of high school and of a secretarial school. The seventeen-year-old brother has graduated from high school. The sixteen-year-old brother is in fourth-year high school; while Ralph, aged eleven, is in seventh grade grammar school. Patient is also in seventh grade, but in a private boarding-school. The sister is bookkeeper in a large hospital. The oldest brother has a clerical position in an insurance office where chances for promotion are excellent. Father was a merchant; a man of good standing in his community; has left very definite influence on family standards and ideals. Mother does all the housework, is a devoted parent, performing her duties with zeal and skill; is intelligent, progressive, fair-minded, ambitious for her children, not reaching for shadows while ignoring realities with which they must reckon. Sister is hard-working, serious, keenly alive to responsibilities borne by mother, and more than ready to carry any she is able to; is unselfish in every way. Brothers also realize the family position and do all they can to make it easier. All four are studious,

Medical
(Patient only)

Social
(Family and patient)

ambitious, and clever. Patient is a sensitive child who has a 'sense of inferiority' at times because of his poor health and low standing in school and at boyish sports. This fact does not show itself in any ill-will toward Ralph, but rather in causing him to think it idle to struggle to keep ahead of Ralph; does not resent favoritism displayed by paternal relatives, although keenly aware of it; is naturally clever and fond of study; not at all self-assertive. Entire family have a fine feeling of unity and affection.

b. *Treatment:*
   1. *Plan:* Supervise patient; encourage good mental and physical hygiene; attempt to bring about understanding of patient's condition by relatives.
   2. *Results:* Plan carried through to success.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Family have no regular physician so welcome suggestions *re* several excellent ones in neighborhood; however, none is needed at present.
b. *Hospital* care is available as long as necessary.
c. *Nursing homes:* Not needed.
d. *Convalescent homes:* Not needed.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* Family can be counted on in every way. Patient's coöperation is good. Home is comfortable apartment of seven rooms providing excellent care for patient.
b. *Relatives:* Mother has no close relatives, but father's brother, sister, and father are closely attached to family. They are generous of time, thought, and gifts.
c. *Benevolent individuals:* Not needed or acceptable.
d. *Private institutions and agencies:* Are available.
e. *Public agencies and institutions:* Not available.

NARRATIVE

ALTHOUGH well developed for his age, Henry was distinctly undernourished, a fact the doctors thought might be due to poor home conditions and lack of maternal intelligence. For this reason and to determine where Henry should go for convalescence, I was asked to visit the home and make a report on the social situation. Accordingly, four days after Henry came into the ward I went out to his home, which was in one of the outlying sections of the city, about a fifteen-minute walk from the electric cars. As I approached the house, I noted that the neighborhood was a pleasant residential one. The houses were attractive and well kept, and were built far enough apart to insure plenty of sunlight to all. The one in which the Brothertons lived was quite new — one of those modern two-family houses which have piazzas front and back, and are provided with yards planted with trees and shrubs. My patient's family lived on the second floor. Their home was most inviting. It was well furnished in a comfortable, cheerful manner. The rooms were in perfect order, yet gave that agreeable impression of being lived in with freedom from constraint which some housekeepers manage to impart to the most scrupulously tidied-up home.

When I explained that I had come from the Hospital to talk with her about her son, Mrs. Brotherton received me very cordially. She had on a pretty gingham house-dress, her hair was neatly dressed, her face, free from cosmetic, showed plainly the lines which were to be expected in a woman of her age.

To my questions she gave full answers, and her own ideas of what sort of information the doctors ought to have showed intelligence. She said that of all her children Henry was the only one who ever gave her cause for worry; not that this was his fault, poor boy; far from it. He was just as clever as the rest; but what could you expect when through a child's entire school life he constantly lost time through illness? No sooner

would he recover from an attack of sore throat and get back to school when another siege would put him to bed for a week or two. Consequently, Ralph had caught up with him and then trouble had begun. Henry could not bear to think that he alone of his family was below his proper grade in school. Moreover, his father's relatives — especially his uncle — could not bear the thought either, and frequently told him so. They openly chided Mrs. Brotherton for pampering Henry, and as a corrective measure they did everything they could to show Henry that Ralph was the kind of lad of whom they approved. Gifts, parties, vacations at the uncle's summer home at the beach came Ralph's way. (I wondered whether anything could be more stupidly cruel. The very thing Henry needed was the beach!) Finally, after much discussion, Mrs. Brotherton yielded to her relatives' suggestion and sent Henry to a boarding-school. The school had a good reputation in every way, and Henry was glad to go, so great results were anticipated. But this time he fell a victim to a new form of disorder, and after a week or so spent by him in crawling around in real pain, Mrs. Brotherton was told to take him away.

She found him shockingly reduced in weight, far from clean, and sleeping in a very cold dormitory. What she had since learned about the diet supplied by the school had confirmed her resolution not to send him back. She was going to see if the head master of the public school attended by Ralph, and to which Henry also would have to go, could arrange to put the boys in different divisions of the seventh grade, thus sparing Henry's pride. When I told her that the boy would be out of school several months as a result of his present illness, she at once exclaimed that this would solve the difficulty, as Ralph would be a semester ahead of him. Furthermore, Henry would have the great moral support to be derived from the Hospital's orders that he remain out of school for a time. Mrs. Brotherton was sure that the reputation of the M.G.H. would certainly inspire respect in her relatives who could

hardly insinuate that the *doctors* were coddling Henry. She thought that it might be a very good plan to have me call on the relatives — at least on the uncle — and explain the medical situation. However, it seemed to me that this might arouse antagonism and that it would be wiser to keep it for the last resort, trying first the effect of the orders as interpreted by Mrs. Brotherton. If this failed to impress the relatives sufficiently, I would gladly see what I could do.

When I reported to the doctors, I was heard with astonishment. They had an entirely different impression of the kind of home Henry came from — an impression gained from seeing Mrs. Brotherton when she visited Henry. I was urged to observe for myself and see whether or not their conclusions were justified. I was forced to admit a few days later that one might easily be misled by the very lavish use of paint, powder, and perfume, to say nothing of a striking costume of vivid hue. One could hardly believe it was the same woman of the lilac gingham and the wrinkled, kindly face. However, I held to my opinion that I knew what kind of woman this was, and presently, after a tonsillectomy (the first one had not been successful), Henry was discharged home to be supervised by me during the next few months.

Things went very well. I carefully explained to Mrs. Brotherton and to Henry himself the principles of mental and physical hygiene which were involved in his case. My advice was readily accepted and carried out faithfully. Henry, wrapped in an old fur coat of his father's, spent long hours on a couch on the piazza. It was one of those very sunny winters, so he was greatly benefited by the sunlight and by the exceedingly generous diet we fed him. The relatives capitulated without me when they saw how rapidly Henry improved both physically and mentally.

Six months later, I withdrew leaving behind me a healthy lad who had a perfectly sound reaction toward his problem. He was back in school and doing well there. Moreover, he had learned that being outstripped by his younger brother, who

carried no handicap in the race for a high-school diploma, was not a disgrace.

COMMENT

One thing stands out very clearly in this history; namely, the need for preventive work in both medical and mental fields. We have here material for rheumatic heart disease as well as crippling of the joints, and for an abnormal sense of inferiority. Of course no one can claim as yet that these evils have been permanently prevented, but it seems a hopeful state of affairs. The case also illustrates the necessity, under which many a hospital social worker must work, of drawing conclusions from obvious facts without asking direct questions. It illustrates again the fundamental point in skill which requires the exercise of care lest she take over any activity which the family can carry without her and of avoiding the invasion of their privacy. One must put two and two together, be guided by intangible things, and try so to establish one's self in the family's confidence that all necessary data will be volunteered as it is needed in the treatment of the problem. The case demonstrates finally what may be expected when social conditions are favorable. Only the slightest instruction and reënforcement of *maternal* authority by *medical* were necessary, chiefly because the social worker was concerned with intelligent persons capable of seeing their mistakes and of changing their course, once the truth of the situation was made clear to them.

E. W.

All sorts of mental and physical disorders in children are frequently explained by the parents as due to the fact that the child fell or was dropped in infancy so as to strike his head. Such stories are purely legendary in almost every case, for the supposed ill effects of the fall are almost never noticed at the time, as they would be if the fall had really done any harm, but are seen months or years later, and then arbitrarily at-

tached to the trifling prior accident because some obvious 'cause' is demanded by the parents' state of mind. Infantile paralysis, feeble-mindedness, and epilepsy are the troubles most often thus falsely attributed to an injury.

R. C. C.

CASE 29

BESSIE SHAPIRO Age 21 *Single*

Admitted to Dermatological Clinic October 6, 1921. Referred to Social Service November 1, 1921.

MEDICAL SOCIAL PROBLEM

Psoriasis in a young girl who is deeply depressed by her condition. Suitable work necessary as therapeutic measure.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Psoriasis with generalized lesions; no lesions on hands and wrists, and not very marked on face.

b. *Prognosis:*
Doubtful, as patient has had nine years of treatment in various first-class hospitals without success.

c. *Treatment:*
Daily starch baths and ointments; two meals a day omitting cereals and fruits; suitable work to keep patient from brooding over her condition.

d. *Additional medical history secured by social worker:*
Patient has never conscientiously carried out treatment prescribed.

Social
(Family and patient)

a. *Analysis:*
Parents are Russian Jews. Came to the United States thirty years ago. The eight children were all born in Massachusetts. Father was crippled by an industrial accident ten years ago for which no compensation was received. Family had very low standard of living by means of which they had been able to save money. Father earns $25 a week. Two brothers earn $12 a week each. Patient has been earning $12 a week when at work. Father owns home of seven rooms, four of which are rented. No data obtained as to amount of rental received. Legal settlement in city in Massachusetts. Father's health is very poor. Mother is so obese that she is practically confined to her chair. One brother has asthma; another has lost several fingers on one hand due to accident with firecrackers. Others of family seem fairly healthy. Parents are almost without education. Some

Medical (Patient only)	*Social* (Family and patient)
	of the children have had some high-school training. Some are still in public school. No information obtained as to their grades. Patient has had one year in high school. She has always read a great deal and has quite a store of information. She writes a fairly good letter, although she frequently uses words she doesn't understand. Handwriting is good, though of a much embellished type. Father runs a power machine in a clothing factory. Brothers work in stock-room and shipping department of the same factory. Patient worked in a department store until recently. Nothing definite is known about parents except that they are ambitious for children and eager to accumulate property even though this means a low standard of living. No data obtained about brothers and sisters other than their willingness to support patient while she is under treatment — an attitude due apparently to a sense of duty rather than affection. Patient is extremely self-centered, very sensitive about her appearance, inclined to overestimate her ability and importance, lacking in will-power — especially in matters of diet and hygiene; is kind-hearted to the extent of helping others with their work, provided it is of a kind she herself likes.
	b. *Treatment:*
	1. *Plan:* Meet patient's obvious need and supervise at least long enough to be sure that she is improving and can be

Medical
(Patient only)

Social
(Family and patient)

trusted to go on alone, or until doctors think further efforts are useless.

2. *Results:* Patient influenced *re* following treatment; mental habits improved; suitable work and room secured; permanent improvement in patient's skin trouble secured to some extent, owing largely to her own improved will-power applied to matters of diet and hygiene.

c. *Sources of information:* Relatives; prospective employers interviewed by patient.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Not needed.
b. *Hospital clinic:* Will treat and supervise.
c. *Nursing home:* Desirable, but too expensive.
d. *Convalescent home:* Not available.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* Family cannot be counted on for anything except financial support; no evidence of bonds of affection. Patient's character makes any help from her doubtful. Her mental attitude is a hindrance.
b. *Relatives:* Cousin can continue to give patient a bed in her home, but will not be of any real assistance.
c. *Benevolent individual:* None interested.
d. *Private agencies and institutions:* Are available.
e. *Public agencies and institutions:* Are not suitable.

NARRATIVE

The physician who was treating Bessie Shapiro for a chronic skin disease at the clinic referred her to the Social Service Department, feeling that she needed supervision if she were to profit by the treatment; for she had, apparently, little self-

control in the matter of diet, which was particularly important, and her mental attitude was unfavorable. Moreover, she could not find work for herself; and he felt it would be better for her to be occupied so that she would have less time to brood upon her condition. Though there were but slight traces of the disease visible on her face, the girl believed that everyone looked upon her with loathing and suspicion.

Miss Barrett found Bessie far from unprepossessing, however. True, she was short of stature and of a swarthy complexion; but she had an intelligent face, a kindly manner, and was neat and tidy in appearance. She declared herself ready to follow instructions in every detail, but stipulated that if she went to work, she must be among people who would not look at her askance. She had had all that she could bear, not only at the department store where she had worked until recently, but also from the family of a married cousin with whom she was living in order to have treatment at the Hospital, and who, she felt, regarded her with disgust.

Miss Barrett's first attack on the problem was upon the medical side. She found that it had been practically impossible for Bessie to carry out the doctor's orders. She had no privacy in her cousin's home, for she slept on a couch in the living-room; she couldn't have the daily starch bath that had been ordered to alleviate the intense itching, for there was no modern plumbing, and hot water in sufficient quantity could not be provided. Her diet as prescribed was two meals daily without cereals or fruit; but she was in no position to dictate what she was to have. Although her family paid for her board, it was really an inconvenience to the cousin to have her in her small apartment. Therefore, as it was too far for Bessie to go back and forth between her own home and Boston for treatment, Miss Barrett decided that first of all she must find some other living-quarters for her, which, with the right sort of work, would provide favorable conditions for her mental and physical recuperation.

Although Bessie was hard to please, Miss Barrett worked

out with her what promised to be a satisfactory plan. She was to have a room with a bathroom and a gas stove in an apartment house near the Hospital, doing dusting and other cleaning to pay for it. These duties would be light enough to allow her to work elsewhere; and a woman who understood the medical situation agreed to employ her for sewing and mending, paying her seven dollars a week.

When Miss Barrett went to Bessie's cousin's house to tell her that everything was ready for her to begin upon her new schedule, she learned that Bessie had gone home, leaving suddenly and giving no reason, only saying that she was not to return to Boston. Miss Barrett wrote to the 'runaway' patient, emphasizing the merits of her plan and urging her to return so that her medical treatment might go on under favorable conditions. She reported that the doctor thought the improvement already made was encouraging, and cautioned her against thinking that local treatments with ointments could be of value unless accompanied by attention to fundamental matters.

Bessie, however, was obdurate. Although her home was even poorer than the cousin's, in that it consisted of only three rooms (four out of seven being rented to another family) she insisted upon remaining there. There was, therefore, nothing to do but to make the best of the situation. The doctor undertook to supervise treatment even at such a distance. Miss Barrett sent Bessie a blank book in which she was to make careful record of her diet and hygiene and of such observations of her condition as she could manage, sending it in to the doctor at intervals. Miss Barrett kept in touch with her through correspondence, exerting herself to make her suggestions and explanations so clear and sympathetic that they could not be misunderstood or resented, but must work for the patient's good.

The reports received by the physician showed steady progress. (These reports continued for a period of two and a quarter years — long after the social record had been closed.)

Moreover, it became evident that the patient was improving in more than one particular, for presently she wrote the doctor that she had finally realized that her recovery was dependent upon her own mental attitude. After she had reached this conclusion, the disease cleared up rapidly. Becoming careless a little later, however, she relaxed her diet, ate late at night and between meals, and presently the lesions on her skin returned. This convinced her effectually of the wisdom of obeying orders, and the last accounts show Bessie holding strictly to the prescribed schedule with corresponding improvement.

COMMENT

This case illustrates the necessity of continuing work in the face of apparent defeat. It shows, too, that in certain cases, astonishing results may be obtained through letters. In the case of this girl, they seem to have done better service than personal contact could have accomplished. This shy, reserved, self-centered girl was not responsive in conversation; but she had always been a reader, and what she read impressed and remained with her. In that crowded home where there was so little chance for privacy or for strictly personal belongings, letters represented both to her, and were the symbols of personal possessions she could not have otherwise. She probably received few or no other letters, certainly none more full of sympathy and regard for her welfare than those from the social worker. What wonder, then, that she read and re-read them, lived in the little world they created for her and so profited insensibly as well as consciously by the whole treatment!

E. W.

While we have reason to hope that this poor girl's disease will remain under control, we must not forget that psoriasis is a disappointing disease, prone to recur even after it is apparently cured, and not always responding the second time to the treatment which apparently helped it before. Certainly we

have reason to believe that the changed hygiene and the improved mental attitude had their effect, and that, even if the skin trouble does recur, the patient will be able to get along and to get satisfaction out of her life in spite of it. For in this as in most chronic disease the morale of the sufferer exerts a conquering influence.

R. C. C.

CASE 30

ANNA HOPKINS Age 36 *Married*

Admitted to ward July 29, 1923. Discharged August 18, 1923.

MEDICAL SOCIAL PROBLEM

Fibroids of uterus; mental disease; post-operative convalescent care; broken home; financial dependency.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Fibroids of uterus removed by operation.

b. *Prognosis:*
Excellent, as patient's general condition is very good.

c. *Treatment:*
At least two weeks' convalescent care.

d. *Further medical history secured by social worker:*
Patient is suffering from paranoia and was recently recommended by psychopathic hospital for commitment to State Hospital for Mental Diseases. Patient has attacks of violent mania.

Social
(Family and patient)

a. *Analysis:*
Patient and husband are negroes; born in Georgia; they are Baptists. The couple have lived in Massachusetts for three years. Have always had difficulty in getting on together, so separated about a year ago. They have no children. Husband earns about $60 a month; patient earns an average of $15 a week. They have no settlement. Neither husband nor patient has any real education. They are illiterate and possess no fund of general information. Husband is a longshoreman. Patient is a laundress. No actual data on character is available, but inferentially one may conclude from patient's mental diagnosis and the broken marital relations that both patient and husband have faulty characters.

b. *Treatment:*
1. *Plan:* Send patient to convalescent home.
2. *Result:* Removal of patient by means of police from convalescent home to psycho-

Medical
(Patient only)

Social
(Family and patient)

pathic hospital and commitment through court to State Hospital for Mental Diseases.

e. *Sources of information:*
Psychopathic hospital; Court.

2. Therapeutic Assets

Medical

a. *L.M.D.:* Not needed.
b. *Hospital:* Not needed.
c. *Nursing homes:* Not needed.
d. *Convalescent home:* Available and suitable.
e. *District nurse:* Not needed.

Social

a. *Family and patient:* Husband has separated from patient; they have no home.
b. *Relatives:* Patient's brothers will support her until she can work.
c. *Benevolent individual:* None interested.
d. *Private agencies and institutions:* Are available.
e. *Public agencies and institutions:* Are available.

NARRATIVE

Mrs. Hopkins was not known to the Social Service Department until one of the surgeons came into the office to say that the surgical wards were very crowded and patients were waiting for admission; therefore, he wanted Social Service to help him make plans for the immediate discharge of several patients who could go if they could be sent to convalescent homes. Among these patients was Mrs. Hopkins.

Miss Warren talked with the patient and learned that she was separated from her husband. She had no money; therefore could not pay for her convalescent care, but would accept it if it could be given to her without charge. This, Miss Warren was able to arrange for, and accordingly within an hour Mrs. Hopkins was on her way to the convalescent home in a taxi paid for by Miss Warren from a fund at her disposal, and escorted by one of the staff members. Owing to the lateness of the hour, no adequate investigation could be made before Mrs. Hopkins was discharged.

Next day Miss Warren discovered that Mrs. Hopkins was known to a psychopathic hospital. Before she could obtain a report from this hospital, the Superintendent of the convalescent home telephoned her that Mrs. Hopkins was acting so outrageously that Miss Warren must remove her at once. Mrs. Hopkins's language was terrible; her actions worse, since she had possessed herself of a razor with which she was threatening all comers. Miss Warren explained that she had just learned of the patient's having recently been known to a psychopathic hospital, but had as yet no details. She would get these at once over the telephone and would then remove Mrs. Hopkins from the convalescent home.

The history at the psychopathic hospital was enlightening, since it showed that Mrs. Hopkins was subject to sudden attacks of mania during which she was very violent. She had been under observation at the hospital and had been recommended for admission to a State Hospital for Mental Diseases. The Judge before whom the patient was brought for commitment, seeing her in a very quiet phase, had been moved by the plea of her brother and had released her in her brother's custody. The latter had evidently taken her at once to the M.G.H. for an operation which had been recommended by the psychopathic hospital physician with the idea of having it done after her commitment. The psychopathic hospital would readmit Mrs. Hopkins at once if Miss Warren would bring her to the hospital, but it was thought possible that Miss Warren could have her go through the Court on the old papers if she applied to the Judge.

Miss Warren's next step was to telephone to the Court where Mrs. Hopkins had been released from custody. She spoke with the Judge himself, who was very much astonished by the turn of events. He advised taking the patient into the local Court, since she was not then in his jurisdiction, and having her committed. This advice did not help Miss Warren any, for the immediate problem was the razor. Who was going to disarm the patient? So, while another staff member

telephoned to the Superintendent of the convalescent home to report that action was being taken, Miss Warren telephoned to the police station nearest the convalescent home. The police officer at the desk said he was powerless to act unless by order of the Court. He was so positive about this that Miss Warren rang off and sought to refresh her memory of the ordinance under which Boston police may take persons to the psychopathic hospital. She found the necessary information and once more telephoned to the police station. After a prolonged though amicable discussion, the officer consented to believe her when she quoted the authority under which he could act when requested to. The next step was the request.

Miss Warren telephoned to the Superintendent of the convalescent home that she must call up the police station and request immediate removal of a person apparently insane. This the Superintendent refused to do, as she thought it meant that she would later have to appear in Court and her professional duties allowed no time for this. At last she understood and promised to act at once. She would telephone Miss Warren what happened.

One hour went by with no report from the Superintendent. Miss Warren feared the worst. Had the razor won the day? Had someone apparently more versed in the law gotten hold of the reluctant police officer? At last she could wait no longer; she telephoned to the Superintendent. The latter's first word told Miss Warren that something cheering had transpired, for the voice was no longer strained. The police had come. They had had time to observe Mrs. Hopkins and convince themselves that she did come within the legal definition of 'a person of apparently unsound mind.' The mere sight of their uniforms calmed Mrs. Hopkins. They were even then on the way to the psychopathic hospital with the patient. Miss Warren apologized for all the commotion, and then telephoned to the psychopathic hospital that the patient would be there soon. At the doctor's request she then tele-

phoned again to the Judge and told him that Mrs. Hopkins would reappear in his Court very shortly.

This time Mrs. Hopkins was really committed, as her brother did not dare to assume further responsibility when he learned of her outbreak. The surgeons and nurses of the M.G.H., when they heard the story, assured Miss Warren that not one of them had seen any indication of mental disease. Nor had either of the social workers concerned with transferring her to the convalescent home.

Miss Warren's responsibility ended when her patient entered the psychopathic hospital. Her connection with this case was a very brief one, although enough had happened to make her feel as if she had worked hard and for a long time.

COMMENT

This, while more dramatic than many similar histories, is not the only one where action taken before the full social history was known has resulted in astonishing situations. Theoretically, social case work should not be done without knowledge of all facts because of the responsibilities assumed by the social worker toward any other institution to which she sends her patient, but in practice is sometimes inevitable because one of the most important functions of a hospital Social Service Department is to make beds available for the acutely ill by placing outside the hospital such patients as no longer require hospital care.

One may say that the surgeon should not have waited until so late in the day before consulting the Social Service, but here again you are faced with something over which neither he nor anyone else had control. Sick persons presented themselves for treatment which they needed at once; there were no empty beds but there were several patients who could leave with safety to themselves. From this proceeded logically the above happenings.

If one cares to go back to a still earlier cause, it is evident that it was the freedom of action conferred on the brother,

against the advice of the psychopathic hospital, which really made all the trouble. In the last analysis the difficulty is found in the fact that legal and medical ideas of insanity do not as yet coincide. As long as one of the parties to the commitment of an insane person disregards the professional advice of the other party, there is potential disaster in the situation.

The consequences here might have been very grave. It was sheer luck that Mrs. Hopkins did not use the razor on herself or someone else.

It should be emphasized that nothing in the patient's behavior in the Hospital aroused suspicions concerning her mental state and her history as given to the surgeons by herself and her brother denied any mental disease.

E. W.

One of the most terrible and mysterious things about insanity is its periods of quiescence in which the patient seems perfectly normal and may deceive a judge or anyone else, especially when that very vague diagnosis 'paranoia' is all that there is to go on. The term has a bad reputation in Court, where it is often invoked with success to save murderers like Harry Thaw from the electric chair. Nevertheless, when alienists declare a patient in need of restraint in an institution, a judge takes a dangerous responsibility in disregarding their advice, whatever the diagnosis.

The social work done in this case seems to me exceptionally good.

R. C. C.

CASE 31

DOMINIC PETRONIO Age 37 *Married*

Admitted to ward April 9, 1923. Discharged, dead, April 13, 1923.

MEDICAL SOCIAL PROBLEM

Pneumonia in a man whose death left his widow and five children destitute.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Pneumonia; strongly positive Wassermann reaction, but no evidence of syphilis. Wassermann reaction attributed to pneumonia. Three weeks prior to admission to ward, patient fell from a ladder while at work and was unconscious for some time during which he was exposed to cold rain; ill ever since.

b. *Prognosis:*
Had been grave from time of admission.

c. *Treatment:*
None.

d. *Additional medical history secured by social worker:*
Patient had been under treatment of L.M.D. for syphilis for years. Wassermann reaction had always been positive.

Social
(Family and patient)

a. *Analysis:*
Patient born in southern Italy; widow born in Massachusetts of Italian parents. Both Roman Catholics. Patient had been in the United States about twenty years. All five children were born in Massachusetts. Patient was not a citizen, but had had a legal settlement in Boston. Widow and first child have had long continuous intensive treatment for syphilis by L.M.D. Child died at age of nine years. Four years lapsed between birth of first and second child. All younger children are healthy and without stigmata. No data on patient's education. Widow is poorly educated, but speaks both Italian and English readily and has a considerable degree of native intelligence. Children are in public schools and doing well. Patient was a fairly steady, reliable workman well spoken of by family. Wife is bright, energetic, aware of her rights under the law, and determined to obtain them; intelligent and with good general

Medical
(Patient only)

Social
(Family and patient)

ideas on hygiene and bringing up children.

b. *Treatment:*

1. *Plan* is to secure allowance for family either from Mothers' Aid or from Overseers' Aid.
2. *Result:* Widow, her sisters and brother interviewed, matters of health, public aid, and possibility of collecting accident insurance discussed. Information supplied to Overseers of Public Welfare and Mothers' Aid Division, State Department of Public Welfare.

c. *Sources of information:*
Social Service Department of another hospital and of a dispensary; relatives; undertaker.

2. Therapeutic Assets

Medical

a. *L.M.D.*: None needed because of patient's death.

Social
(Family only)

a. Widow and children are united by strong affection. Widow is a good home-maker and mother. Comfortable home of five rooms; rent $14 a month.
b. *Relatives:* Widow's sister and brother interested in family; in fairly good circumstances, but not able to support family.
c. *Private agencies* will not act as case is one for public relief.
d. *Mothers' Aid* is available if mother's character comes up to standard; otherwise Overseers' Aid is available. In either case, family can be adequately provided for.

NARRATIVE

THE doctor in charge of a medical ward came to me one afternoon to ask for immediate help for the family of a patient who had just died. He feared that the widow was wholly without money. She was expecting, he knew, to collect something on an accident insurance policy; but he doubted whether she would be able to do so, as there was practically no connection which could be demonstrated between the accident and the pneumonia which had caused her husband's death. He gave me the medical history of the case to look over before I began work upon it; but I found nothing of consequence except several strongly positive Wassermann reactions. The doctor said that, as there was no clinical evidence of syphilis, these were probably due to the pneumonia.[1]

Upon inquiry in the ward, I found that Mrs. Petronio had left the hospital. The head nurse told me that her brother had taken her to his home; but no one knew where he lived. It was too late to find out that day whether the family was known to other social agencies, and I had to leave that point until the next. I went at once to the Petronio home, which was in the outskirts of the city in a pleasant, open neighborhood. The family was absent, however, and none of the neighbors could give me any information as to their whereabouts, except that Mrs. Petronio and the children were staying with relatives in the opposite end of the city and would not return until after the funeral. Further questioning failed to bring forth any helpful data.

The next morning, I found that another hospital in the city had a social record of Mr. and Mrs. Petronio and their oldest child, who had all been treated for syphilis, and then, at their own request, had been referred to a dispensary which was nearer their home. The record gave no name of relatives, and the dispensary had no record of patients of that name ever having come to them for treatment. Thus baffled, I turned

[1] See comment.

my attention to the undertaker who had claimed Mr. Petronio's body.

By the time I could find out who he was and communicate with him, two days had gone by. He gave the address of the house where Mrs. Petronio was staying and reported that the funeral had taken place that morning. He feared the widow was in financial distress, as he had been told that his bill could not be paid until accident insurance was collected. At the funeral, just before leaving for the church, a collection for the family had been taken, which, however, netted only about fourteen dollars. The undertaker, a friendly, generous Irishman, assured me that he would not press for his money and said he had made the bill as low as possible, though Mrs. Petronio, like many Italians, had insisted upon making arrangements on a lavish scale. When he told me the amount of his bill and what it covered, I thought his charges unusually moderate.

Armed with the address, I found Mrs. Petronio without great difficulty. She was staying with relatives in dark, dirty rooms in a large tenement building in a crowded, disagreeable quarter of the city. When I carefully broached the matter of financial assistance, she told me she had applied for Mothers' Aid immediately after her husband's death, relatives who were in receipt of such aid having instructed her as to how to secure it. Pending action on her application, the Overseers of Public Welfare were giving her temporary aid.

Although Mrs. Petronio mourned her husband sincerely, she was not the sort of woman to abandon herself to grief when there was work to do. The power of native intelligence plus good character was evident in her. She captured one's interest by her attractive personality and held it by her forcefulness in meeting and solving her problems. Already, a lawyer had been consulted in regard to the insurance and he had instructed her to get medical proof from the Hospital upon which to base her claim. I repeated to her what the doctor had said as to the difficulty of establishing any connection between the accident and the death by pneumonia.

Presently I spoke cautiously about the treatment that she, her husband, and child had had for syphilis, and asked whether they had reported to the clinic to which they had been referred. Mrs. Petronio admitted that they had not done so, because they had preferred treatment by a private physician. The child had died at the age of nine, having been sickly all its life. Her own treatment had been thorough and had resulted in negative Wassermann reactions for a number of years. She had received treatment during each pregnancy since then and all of the children born had been healthy. Her husband's treatment, however, had never satisfied his physician, as his Wassermann reactions were constantly strongly positive. Personal experience had given Mrs. Petronio accurate information. Rarely have I heard even highly educated persons display more knowledge and judgment as to treatment for syphilis than was shown by this comparatively ignorant woman.

I told her that the fact of syphilis in her husband would probably be an additional obstacle in the way of her collecting the insurance. In taking leave, I suggested that she come to our clinic if she or the children needed medical treatment, as the Overseers would not pay for private treatment, and if she came, I told her to ask for me. I promised to give the Overseers and the State authorities the medical data necessary for her to receive Mothers' Aid. And I advised her to return to her own tenement, as the surroundings were so much more desirable for the children than here with her relatives. Although she dreaded the loneliness, she said she would make any sacrifice for the good of the children. She expressed her gratitude for what the Hospital had done and promised to come in to see me and let me know how things turned out.

I wrote immediately to the Overseers and to the Division of Mothers' Aid at the State House giving them the facts as to Mr. Petronio's death, my own opinion of Mrs. Petronio's intelligence and character, and my belief that she was of the type to whom Mothers' Aid should be extended, and notifying

them of the possibility of treatment for the family at the M.G.H. After reporting to the doctors, who were deeply interested in both the medical and the social aspects of the case, I closed my record.

About two months later, Mrs. Petronio came in to see me, accompanied by two sisters, a niece with her baby, and her own two youngest children, aged three and one. The occasion was one of much ceremony and good feeling. For a time we all sat in a circle and enjoyed the three babies, all of that singularly engaging nature common among Italians no matter how far removed from Italian nativity. Presently Mrs. Petronio disclosed the object of their visit; she reported that the insurance could not be collected, but that Mothers' Aid was being received and all was well. The Petronios were in their own home and were to remain there. And there we will leave them, relying upon the efficient and kindly supervision of the State of Massachusetts functioning through the Mothers' Aid Division of the Department of Public Welfare.

Since writing the above, I have learned that one of the Petronio boys became so unruly that he was committed through the Court to the State Training School for Boys. This is not, however, to be attributed to the lack of his father's control; for the records show that the boy was delinquent before his father's death, though the facts were not discovered until supervision by a social agency brought them to light, fifteen months later. The school is in an ideal country neighborhood at a distance from Boston and the boy will be under its care until he is twenty-one, some six years hence. If he does well in every way, he will be released, meantime, on parole.

COMMENT

This case illustrates how the Social Service Department of a hospital may reach out into the community and make sure that the widow and children of a patient who has died are being fed and sheltered. In this particular instance, the widow

had already learned of a source of help and was a resourceful woman; but in many cases the situation would have been desperate without the help and guidance of a social worker. As it was, she was able to report favorably upon Mrs. Petronio when she supplied the public agencies with the medical report. For the law under which Mothers' Aid is granted allows considerable freedom of judgment to the Overseers of Public Welfare. If a mother's character is not good, if she has not sufficient intelligence and judgment properly to expend the cash allowance given as Mothers' Aid, she is usually not referred to that department, but is given Overseer's Aid instead, which means that she receives the necessities of life, but not much ready money. The social worker was also able to obtain medical data of interest to the physicians.

A further point of interest in this case is the fact brought out that there was no attempt made by the hospital which sent Mr. and Mrs. Petronio to the dispensary to follow the matter up and learn whether or not they reported for treatment. It would seem advisable for a social worker to keep in touch until she is sure that treatment is being received; and yet in this case the social worker terminated her connection with the case as soon as she had notified the dispensary that the Petronios had been sent there. No doubt in the pressure of more urgent cases she relied too much on the Petronios doing as they were told — a mistake we are all apt to make in such circumstances.

E. W.

Although this patient's positive Wassermann was in all probability due to his syphilis and not, as the hospital physician surmised, to his pneumonia, it is important that everyone who hears about Wassermann reactions and syphilis should realize that this reaction is not always due to syphilis, but may be produced by many diseases which cause *fever* or *jaundice*, and probably by many other diseased conditions not yet clearly understood. Unjust suspicion of syphilis and

useless or harmful treatment for it may otherwise burden the patient and his family. Social workers should be especially careful not to suppose that they can interpret and pass on to others this and other medical terms about which our knowledge is so faulty that serious misunderstandings follow. They should learn *which* medical terms are simple, finished, and definite in their meanings (diabetes and erysipelas, for instance), and which ones are used which have very different meanings according to various modifying conditions often not mentioned. Cancer, for instance, has one meaning not necessarily serious at all when it refers to a small superficial growth on the face; quite another and usually fatal significance when it refers to a growth in the stomach. Tuberculosis is a terrible word when it means disease in the larynx or the brain; quite a mild word when it means glands in the neck or at the root of the lung.

Laboratory phrases and psychiatric diagnoses are especially difficult and dangerous for social workers to handle.

R. C. C.

CASE 32

GIOVANNI TREMURI AGE 34 *Married*

Admitted February 28, 1920. Discharged June 12, 1920. Wife untrustworthy.

MEDICAL SOCIAL PROBLEM

Exophthalmic goitre; illness of bread winner resulting in insufficiency of income; worry and alarm.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Exophthalmic goitre with a considerable degree of thyrotoxicosis, metabolism + 69 prior to operation — 49 on discharge.

b. *Prognosis:*
Is good.

c. *Treatment:*
Patient is to have operation as soon as general condition is sufficiently improved.

d. *Additional medical history secured by social worker:*
None.

Social
(Patient and family)

a. *Analysis:*
Patient and wife are natives of Italy; Roman Catholics. Patient has been in the United States eighteen years; wife came as young child. They have lived in Massachusetts for six years. The two older children, aged ten and seven, were born in New York; the two younger, aged four and one, were born in Massachusetts. Patient has earned about $20 a week. Rent is $20 a month for four rooms up two flights. Patient is a United States citizen and has a local settlement. The health of wife and children is good, although the seven-year-old boy has had infantile paralysis which necessitates a brace on his leg. Patient and wife are both poorly educated, although patient has considerable knowledge of singing. He speaks English fairly well; wife speaks fluently. The two older children are in the fourth and first grades of the public school. Patient has been a waiter; has sung in chorus of

Medical (Patient only)	*Social* (Family and patient)
	opera companies. Patient is honest, reliable, affectionate, fond of singing and acting; of distinctly emotional temperament. Wife is devoted to patient and children; is untrustworthy in matters concerning finances. No outstanding characteristics of children are noted.
	b. *Treatment:* Patient reassured, encouraged, and entertained. Situation fully explained to wife in attempt to enlist her more intelligent aid. Family Welfare Society called in to treat the social problem. Supervision given over a period of fourteen months.
	c. *Sources of information:* Social agency in home town.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Not needed, but available.	a. Affectionate relationship between patient and wife, who are temperamentally well suited to each other. Comfortable home.
b. *Hospitals:* M.G.H. will carry out treatment.	b. Wife's *relatives* are very well-to-do and aid generously.
c. *Nursing homes:* Too expensive.	c. No *benevolent individual* interested.
d. *Convalescent homes:* Not available.	d. *Private relief agency* called in.
e. *District nurse:* Needed only in emergency.	e. *Public aid* is available if problem becomes one of too long duration for private agency.

NARRATIVE

Mr. Tremuri seemed greatly upset by his surroundings in the ward and shed tears on the slightest provocation to an extent rather unwarranted, even with his disease; so I was not surprised when the doctor asked me to talk with him. He

thought he might have some worry which I might discover. Accordingly, the next time I went to the ward, I asked Mr. Tremuri what I could do to relieve his mind and allow him to settle down quietly to his treatment. It was not at all difficult to find out where the trouble lay, for Mr. Tremuri was one of those amiable Italians who respond very readily to friendly advances. He said he was anxious about his wife and children because he had left very little money at home. For six months he had not been able to work and his savings were nearly exhausted. Here was he, having the most delicious meals served to him, and he feared his family were actually hungry! I assured him that I would find out at once how things were at home and bade him not to worry. Mr. Tremuri seemed relieved and was soon chatting about his past life. From the age of fourteen he had been a waiter — first in Italy and then in the United States, during the eighteen years he had been here. Possessing what he called 'a very nice Caruso voice,' he had had numerous engagements in the chorus ranks of grand opera companies; he had photographs of himself in costume which he showed me with delight. These pictures confirmed my impression that the patient had recently lost much weight, for they all showed a man of very ample proportions of the type so often associated with tenor voices. Aside from the delight in practicing his art, it brought him more money than he got from his trade, as he earned one hundred and twenty-five dollars a month on the stage as against about twenty dollars a week as a waiter.

His wife, Julia, had the Italian appreciation of music even if she had lived in America since infancy, and was very good about his absence on tour. Mr. Tremuri was sure that his oldest boy, who already sang well, was destined for a great career. Whenever he mentioned his wife and children, his big brown eyes filled with tears, which rolled down his cheeks and splashed on the red blanket coat his solicitous nurse had put on him. But the tears were really terrible when he told about the second boy, who had been an 'infant' ever since an illness

several years ago. Searching questions brought out the fact that the child had had infantile paralysis.

Mr. Tremuri's home was in a city not far from Boston, and I asked the local Family Welfare Society to visit it and find out whether he had cause for anxiety. Their report showed that all was going well with the family. Mrs. Tremuri's relatives in Philadelphia, who were in prosperous circumstances, were in close touch with her and sending her money regularly. She was also receiving ten dollars a week from the public funds, and had been presented with a goodly sum as the result of a collection taken up among her husband's fellow workers. Mr. Tremuri had no reason to worry about her except on the score of her over-eagerness to discover sources of aid and her unscrupulousness as to means. The children were thriving. The one referred to as the 'infant' was under treatment at a good clinic; the outlook was favorable if the child attended regularly, and the Society was arranging for a friendly visitor to go with him, thus relieving Mrs. Tremuri and allowing her to visit her husband daily.

The operation, in three stages, was a complete success. Mr. Tremuri was in the Hospital for over three months. Then he went home for two months, coming to the Hospital regularly for X-ray treatment. I visited him occasionally to make sure everything was all right. Finally he was readmitted to the ward for the last operation; ten days after this he was discharged from the ward. He had gradually become less emotional, although always dramatic. When I sent for him to report at the clinic three months later, his metabolism and pulse were found by the physician to be almost normal. Four months later, I got him in again. He was at work at the best job he had ever had, earning forty dollars a week on full time. His hands were so steady that trays full of soup contained no terrors for him and gratified patrons were liberal in their tips. The doctors declared that the patient was in excellent condition and need not report again.

Since the Family Welfare Society was working with the

family, I had no further responsibility. So with many expressions of mutual esteem Mr. Tremuri and I parted.

COMMENT

This case shows the early need of social service in certain types of illness. Without assurance that his family was comfortable, it is doubtful if this patient would have remained in the Hospital for his treatment. At all events, even if he had remained, he would have worried so constantly as to endanger the good effects. Owing to the coöperation of the family case work agency, the hospital social worker was enabled to confine herself to the medical aspects of the case. The subordination of the purely social problem, such as Mrs. Tremuri's unscrupulousness as reported by the Family Welfare Society, to the medical-social problem represented by her husband, must in the nature of things occur now and then. But unless there is someone to whom she may hand over such responsibility, the medical-social worker may have to deal with the whole situation.

E. W.

This disease, exophthalmic goitre, is one in which the need of *rest*, whether before an operation or instead of it, is always recognized. But too often physicians act as if staying in bed was certain to bring rest to mind and emotions as well as to the muscles. The physician and the nurse may ignore the obvious fact that a patient may be *more* restless when confined to bed, may be using up more strength in bed than out of it, unless we can succeed in helping him to peace of mind. This may not be in our power, but at least we should attempt it, along with whatever other treatment, chemical or physical, that we administer. The social worker's help in this direction seems to have been in this case an important factor in bringing the patient to a point where he could safely and helpfully be operated on.

R. C. C.

CASE 33

OSCAR ANDERSON AGE 62 *Single*

Admitted to ward February 27, 1920. Discharged July 26, 1920.

MEDICAL SOCIAL PROBLEM

Fracture of femur and both bones of right forearm; no relatives or friends; no home; no money; eligible for compensation from employers.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Fracture of the femur and both bones of right forearm; arterio-sclerosis. There is union in the femur and in the radius, but none as yet in the ulna.

b. *Prognosis:*
Poor for complete recovery of use of limbs because of the arterio-sclerosis.

c. *Treatment:*
Hospital care at the M.G.H. until union has resulted; thereafter probably baking and massage in Out-Patient Department.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient is a native and subject of Norway; a Lutheran; has sailed the sea under Norwegian flag from age of fourteen until about five years ago. Since then has worked as a laborer in shipyards, because, although he has always been very healthy, he could no longer stand the exposure incident to a sailor's life. He has long since lost track of his relatives and he has no friends and few acquaintances. His wages in the shipyard were $21 a week, from which he has managed to save a small sum, but this has been spent since his accident. His rent for one room in a lodging-house is $3.50 a week. Of education he has none in the strict sense of the word; ability to read and write very simply, but he has a good mind and a large store of information; can make shrewd use of what he has learned from observation. Integrity of character apparent in his face; has a quiet, reserved manner, keen interest in humanity, self-reliance and self-

Medical (Patient only)

Social (Family and patient)

respect; is energetic, loves to work; is not afraid of any honest kind. Loyal and appreciative of help, but prefers starvation to taking alms.

b. *Treatment:*

1. *Plan:* Assist patient in collecting what is due him because of accident while at work. If possible get him into an old man's home, by choice a 'Sailor's Snug Harbor.'
2. *Result:* Patient collected $1500, but refused to capitalize it by using it as an admission fee to an institution; he preferred to live on it very frugally. Patient had fairly good results from long-continued baking and massage.

c. *Sources of information:* Employer, landlady and lawyer.

2. Therapeutic Assets

Medical

a. *L.M.D.*: Is not needed.
b. *Hospitals:* M.G.H. will treat as long as necessary in wards and at Out-Patient Department.
c. *Nursing homes:* Are too expensive.
d. *District nurse:* Is available if needed.

Social

a. *Family and patient:* Patient has no family and no home. His own courageous outlook on life will mean a great deal.
b. *Relatives:* Patient has no relatives.
c. *Benevolent individual* is interested.
d. *Private agencies and institutions:* Are available to a limited extent.
e. *Public almshouse* care is available when funds are exhausted.

NARRATIVE

On the very day this sturdy, impressive Norwegian came into the ward, the surgeon in charge of him asked Miss McDermott, the social worker assigned to fracture cases, to see what

could be done to help him. In spite of his years ashore, the picturesque old man with his silver hair, twinkling blue eyes, and ruddy color was still unmistakably a sailor. Though his manner was reserved, his expression was kindly, and he accepted Miss McDermott's offer of assistance as part of the complicated treatment he was receiving.

Mr. Anderson related his story in a few words — the familiar history of the boy who goes to sea, sails it until he is nearing old age, then, without social ties of any sort, drifts about on shore until chance anchors him here or there. His accident was due to his attempt to prevent a heavy timber from falling upon a fellow workman — a successful attempt in that he alone paid the penalty of fractured bones. His employers, however, were trying to evade paying compensation for his injuries, which, strictly speaking, had not actually been sustained in the discharge of his duty — he had merely happened to be near the scene, his own work being in another department. Such offers as they had made through a foreman, Oscar had refused, with the intention of bringing suit unless a reasonable settlement should be proposed. Meantime, the employers would pay the hospital bill and he need not worry, for he had enough money saved to enable him to hold out after his discharge from the hospital until he could get what was due him.

Although Miss McDermott saw Oscar regularly during the next five months, there was practically nothing she could do for him until after he was discharged from the Hospital. By that time he was in fairly good condition, though his right hand would never again be of service. His first move after leaving the ward was to go to his employers to talk about a settlement. They offered him twenty-five dollars in addition to his hospital expenses. He refused the offer and consulted a lawyer whom he had heard someone mention. The latter took the case on a contingent fee and set about trying to settle it out of court, since, as he told Oscar, the docket was so crowded that the case could not come up for ten months.

A long wait was more than Oscar could finance, and after a few days, during which he heard nothing from the lawyer, he came to Miss McDermott and besought her to see if she could hasten affairs. Wherefore, after looking up the lawyer, whom she found to be of good standing, Miss McDermott called on him. She learned from him that Oscar's employers were playing for time, giving first one excuse, then another, for being unable to confer about the matter. Nevertheless, he was still hopeful of settling it out of court.

During the next four weeks Miss McDermott kept in close touch with Oscar, encouraging him and helping him plan for the future. She proposed his entering an institution when he should receive his money, and this prospect seemed to appeal to him, particularly if he could get into a place among other sailors. During this time the lawyer of the employers came to the Hospital to get the necessary medical data, and she spoke with him, endeavoring to present fully the social side of Oscar's case.

Miss McDermott inquired frequently as to whether Oscar's savings were holding out and Oscar was always reassuring. But one day, about a fortnight after Miss McDermott had seen the lawyer, when he called at the House Social Service Office after his treatment in the Out-Patient Department, Miss Carrington saw that he looked white and fatigued. He was distressed not to find his own social worker, who happened to be out of the Hospital, but Miss Carrington talked with him and gradually persuaded him to tell her frankly what was troubling him. It came out that he was almost exhausted by the course of underfeeding he had adopted in order to make his money hold out until his lawyer could effect a settlement. He was living on bread and tea with an occasional square meal at the invitation of his kind-hearted landlady.

Miss Carrington insisted upon his accepting enough money to carry him along properly until Miss McDermott could come to see him and help him plan further. He accepted it only as a

loan. Later, when Miss McDermott suggested his applying for aid to a private social agency to tide him over, she had a long, difficult struggle before she could persuade him to agree to do so. His reluctance to take money which he had not earned, particularly when it was disbursed by 'young ladies,' was so great that every one who knew him rejoiced when the pressure came to an end. At the end of four weeks, his lawyer secured an offer of fifteen hundred dollars cash from his employers, payment of the hospital bills, and reëmployment at a suitable job as soon as business picked up enough to warrant a little expansion. Oscar accepted the offer at once, radiant with satisfaction.

After he had settled with his lawyer, paid two weeks' rent which he owed, and bought himself a new suit of clothes, he had about twelve hundred dollars left. He appeared at the House Social Service Office to receive the congratulations of his friends, then called at the relief agency to repay what had been advanced to him there. From no one, however, would he take advice as to the use of the remainder. As a matter of fact, there was no home for the aged which met his case; in one instance, he lacked three years of the required age of sixty-five; for another, he must have been a sailor up to within a short time of his application; while for the third he did not care. He reckoned up carefully, found out how long his money could be made to last without work and how much further it could be stretched with work, and decided to live on it as frugally as possible. If he could not find work to help out, very well; he would go on as long as he could be comfortable, then he would enter the State Almshouse.

For another three months he continued to report to the clinic, at the end of which time he was discharged. Gradually he drifted away from the House Social Service, but not before he had been carefully instructed as to the preliminaries to entering the Almshouse in case he should wish to go at a time when he could not get into communication with them.

Then off he sailed, the staunch old craft, a little the worse

for the storm he had weathered, but seaworthy still, and happy because he had been allowed to sail on a course of his own choosing.

COMMENT

It often happens that men receive injuries while at work and yet do not technically come under the Workmen's Compensation Act. In such cases, unless they have the benefit of disinterested advice as to their rights under the general laws, there is every chance of unfavorable settlement through delay and sharp practice on the one hand and ignorance or stupidity on the other. In this case the employers were apparently trying to wear out Oscar's ability to wait until he received a just offer; and they would have succeeded if there had been no one to finance him meantime. In the case of a different sort of employer, of course, everything would have been different; many employers are ready and eager to do the honorable thing, and all that the patient needs is someone to act for him while he is chained to bed or to a wheel-chair or crutches.

This case illustrates the sturdy self-respect which impels a patient to pay hospital and other bills and to resist alms as long as possible. It shows, too, how the social worker honors that quality by standing aside and allowing the patient to choose for himself after she has done what she can to explain the alternatives to him.

E. W.

CASE 34

MARIETTA SIMPSON Age 71 *Married*

Admitted to ward November 30. Discharged February 28, 1921.

MEDICAL SOCIAL PROBLEM

Fractured femur; old age; insufficient income.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Fractured femur.

b. *Prognosis:*
As there is a fairly good union of the femur, patient uses crutches fairly well; is slowly regaining her strength; outlook is encouraging. Pain in leg will disappear as patient uses it.

c. *Treatment:*
Patient will require nursing care until she is strong enough to discard crutches. She must be encouraged to rely on herself and to use leg in spite of some pain.

d. *Additional medical history secured by social worker:*
None.

Social
(Family and patient)

a. *Analysis:*
Patient and husband are natives of New England; Protestants, members of the Congregational denomination. The couple have never had any children. They have lived for years in the South End of Boston where Simpson has been employed as a clerk in a number of offices. His wages have always been small, but, with good management and much self-denial on their part, have generally sufficed. Occasionally the Family Welfare Society has supplemented the income. Lately, Mr. Simpson, who is a year or two older than patient, has been barely able to work and employer has kept him only from sympathy. Their health has been good and they have found happiness in each other; are sufficiently educated so that books have been a sufficient source of recreation. They are universally well spoken of. Patient is a cheerful, sweet-tempered old lady whose affectionate nature is centered on husband. He is dependable,

Medical (Patient only)	*Social* (Family and patient)
	honest, devoted to wife, and considerate of every one. b. *Treatment:* Free treatment secured at M.G.H. Funds raised for providing a nurse-housekeeper for patient and for contribution toward admission to Home for Aged for both of them. Encouragement of patient and husband. Coöperation with Family Welfare Society in plan to send couple to Home for Aged. c. *Sources of information:* Social agencies; church; Board of Lady Visitors; head nurse.

2. Therapeutic Assets

Medical	*Social*
a. *L.M.D.*: Is not needed. b. *Hospitals:* Hospital care is not necessary. c. *Nursing homes:* Too expensive. d. *Convalescent homes:* Not suitable. e. *District nurse:* Not available, as no bedside nursing is requisite.	a. *Family and patient:* Husband is too feeble to do much for patient beyond what his love and encouragement can accomplish. Patient's own intense desire not to be a burden and her courage and optimism will do much. Home, consisting of three rooms up one flight, is fairly comfortable. b. *Relatives:* Patient has a brother who will do all he can, but it is not much. He has children who are much interested in patient, but are not able to give financial aid. c. *Benevolent individual:* Several of the Lady Visitors of the M.G.H. are attached to patient and will provide funds for nurse at home and any other constructive help. d. *Private agencies and institutions:* Family Welfare Society is already active and will take full charge of case. Couple is eligible for Home for Aged. e. *Public agencies and institutions:* Public institutions are available, but not desirable for this couple.

NARRATIVE

One morning while I was visiting in a surgical ward, the Head Nurse asked me whether the surgeons had referred Mrs. Simpson to me. She said that she was to be discharged soon, and she feared the home conditions were not suitable for her after-care and suspected that the old couple were too proud to explain the fact to the doctors. She went on to say that Mrs. Simpson was an excellent influence in the ward, never complaining and helping others to forget their sufferings. Every one loved her.

Mrs. Simpson's appearance was in accord with this. I found her a pretty old lady with sparkling blue eyes, pink cheeks, and wavy white hair becomingly dressed, whose self-reliant manner showed her more accustomed to helping others than to seeking help. As I talked with her, she admitted, in a dignified, reserved way, that it would be hard for her for a time after she went home, because her husband would necessarily be out of the house the greater part of the day, although his work was so near that he could have his luncheon at home. Furthermore, the preparation of the meals and waiting on her would tax his slight strength severely. To spare him, Mrs. Simpson gave her consent to my trying to arrange for a nurse to come to her for a few weeks until she could get on alone.

My next move was to ask the Family Welfare Society if they knew the Simpsons. The district secretary informed me that they knew them and had written to the Social Service Department two months earlier to inquire about the patient. I told her we had not received the letter and had not known about the patient until an hour ago. She confirmed what Mrs. Simpson had said to me about the difficulty of care for her at home and said that she ought to have someone who could attend to her needs, prepare the meals, and look after the rooms for a few weeks. If the money could be raised, she knew a good practical nurse who could do all this, whose charge was sixteen dollars a week. I promised to see what I

could do. Later that day, after a conference with the Ladies' Visiting Committee, I was authorized to put fifty dollars at the disposal of the Family Welfare Society for the purpose of providing Mrs. Simpson with a nurse after her discharge from the Hospital.

Under these conditions Mrs. Simpson returned to her home and got on fairly well. But poor old Mr. Simpson began to fail rapidly. He was not able to work and the Family Welfare Society suggested getting the old couple into the Home for the Aged, the admission to which was four hundred dollars. Mr. and Mrs. Simpson had one hundred dollars which they had hoarded for years to prevent the possibility of their burial as paupers; and since, as residents at the Home, their burial expenses would be provided for, they were glad to make this available. The Family Welfare matched this with a like sum and the Church would do the same if I could find the remaining hundred. Again I appealed to the generous Lady Visitors, who were ready to respond. Mr. and Mrs. Simpson were admitted to the Home within a few months, the Family Welfare Society standing by faithfully meantime.

When the old couple moved into their new home, they took with them the most prized of their possessions. Spending their last years together, surrounded by their own furniture and household treasures, they have no regrets because of giving up their little home. They are visited by old and new friends and are content and happy.

COMMENT

This case illustrates the successful intervention of social agencies in bringing about a happy, peaceful end to the lives of an old couple no longer able to provide for themselves. It was not a difficult matter to accomplish. They had none of the disagreeable traits which, often intensified by age, complicate the problem of aid; and they were fortunate in not having anything in the nature of chronic illness to prevent admission to an institution which cannot receive applicants who are ill,

though it cares adequately for those who become ill after entrance. The only real social difficulty, the lack of money, was the most easy to overcome in such a problem.

E. W.

It was a Godsend that the Home to which they were admitted was willing that they should bring with them 'their own furniture and household treasures.' Almshouses usually do not, perhaps cannot, permit this and the misery of looking forward to an almshouse is aggravated by this rule. Next to their memories of the past and their hopes of heaven, old people often prize their familiar 'things' and cannot successfully be transplanted without them.

R. C. C.

CASE 35

BRIDGET GROGAN Age 24 *Widow*

Admitted to Emergency Ward October 18, 1921. Discharged October 19, 1921.

MEDICAL SOCIAL PROBLEM

Attempted suicide by iodine poisoning in a young widow.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Iodine poisoning with suicidal intent.

b. *Prognosis:*
Good. No strictures will result.

c. *Treatment:*
Patient needs no further medical care.

d. *Additional medical history secured by social worker:*
Repeated attempts at suicide by gas, iodine, and jumping out of window.

Social
(Patient and family)

a. *Analysis:*

Family: Parents, brothers and sisters are natives of Canada of mixed Irish and French stock; Roman Catholics. Have been in the United States about three years and have therefore no legal settlement. The father died shortly after arrival in United States; mother has a chronic disease apparently nearing its termination. Sisters and brothers are healthy. There is no history of insanity, feeblemindedness, or epilepsy. The educational attainments of group are only fair, mother being comparatively illiterate. Brothers have steady employment in various industries earning good pay. There is no history of moral defects.

Patient: Patient has a child of eighteen months. Was widowed soon after birth of child. Attempts at suicide on several occasions have not impaired her health. Has worked as a mangle feeder in a laundry for two years earning $13 a week. Poorly educated; devoted

Medical
(Patient only)

Social
(Family and patient)

church member; of quiet and retiring disposition; not interested in men until she met her husband; not deeply attached to him; not affectionate nor considerate toward family; very little maternal feeling.

b. *Treatment:*
Family: Home visit; discussion of situation; interpretation of it simplications; advice in handling it. Confidence won.
Patient: Friendly contact made and coöperation secured. Situation discussed; advised to seek suitable medical treatment.

c. *Sources of information:*
Family; other social agencies; police; L.M.D.; head nurse.

2. Therapeutic Assets

Medical

a. *Hospitals:* Psychopathic is available for observation.

Social

a. *Family and patient:* Family can meet all financial obligations, but cannot give intelligent supervision. Not much help can be expected from patient in carrying out treatment.

b. There is a large circle of friends here and in Canada, but their help is not needed.

c. No *benevolent individuals* are interested.

d. *Private agencies and institutions* acquainted with patient and family are: Child-placing agencies, Infants' Asylum, a Dispensary, M.G.H.

e. *Public agencies and institutions* available are: Psychopathic hospital for observation; State Hospital for Mental Diseases for custodial care and treatment.

NARRATIVE

One afternoon, a social worker and a senior House Officer, meeting in the corridor, paused to discuss a patient. Before they separated the latter remarked that he hadn't referred to her another patient about to be discharged from the Emergency Ward because she didn't need her aid. An attempt at suicide had done her no harm.

The social worker pricked up her ears and began to ask questions. She learned that about one o'clock that morning the police from a near-by suburb had brought in a girl of twenty-four who had swallowed two ounces of iodine in a fit of depression. As the girl had a home to which to return, the House Officer took it for granted she would be all right; the fact that the home was a furnished room, and that she was a widow with an eighteen-months-old baby hardly seeming pertinent to the present situation.

The social worker told the doctor that she wished, nevertheless, to investigate and asked that the patient be kept in the ward until she could talk to her. As soon as she laid eyes on the girl, she felt she was abnormal; her expression was dull and her eyes fixed in a vacant stare. An interview of half an hour having confirmed her suspicion of mental disease, she told the doctor she believed something was wrong and requested that the patient be kept until morning while she visited the family that evening. He agreed and the patient readily agreed to remain.

The social worker reached the mother's home about half-past five and remained two hours. The home was a five-room tenement (for which they paid twenty-seven dollars a month), neat, clean, and comfortably furnished. Mrs. Murphy, obviously seriously ill, lay on a sofa in the kitchen while her daughter-in-law got supper. Together they told the story of repeated efforts on Bridget's part to commit suicide, the attempts antedating her marriage and having little or no relation to periods of stress. As a matter of fact, Bridget had

never seemed distressed over things which troubled others: she took her widowhood cheerfully; though she was fond of her baby, who had been placed out in a foster-home through the efforts of the parish priest, and occasionally went to see him, she did not seem to want him with her. She was in no sense estranged from her family, but she preferred not to live in her mother's home.

It was apparent that the mother and sister-in-law saw nothing unusual in all this. The younger woman said she would do anything she could for Bridget, but that she could not undertake to care for her. Neither she nor the elder Mrs. Murphy wanted Bridget to come to their home because of the responsibility of being constantly on guard against her attempting suicide. Apparently this responsibility did not weigh upon them if Bridget were living elsewhere. Possibly the fact that she had twice endangered the life of the whole family by turning on the gas in her attempts influenced them, though they did not say so. They readily agreed to have the girl sent to the Psychopathic Hospital and promised to talk over the matter with the three men of the family and to report the result to the social worker in the morning.

The next day the social worker consulted the social agencies to whom Bridget was known. A child-placing agency reported an application on her part for board for the baby. They had seen her only once; no action had been taken and no social data obtained. The police reported that they had been called to the drug-store where the young woman had purchased and swallowed the iodine. They had taken her to a physician who had given her first aid and sent her to the M.G.H. The doctor, who had been in attendance during the patient's confinement eighteen months before, told the social worker that he considered Bridget a moron (i.e., feeble-minded). The confinement, uneventful in itself, had been followed by an attempt at suicide. The doctor had no acquaintance with the family situation and had noted no friction.

The social worker reported her findings to the physicians,

and it was decided to send Bridget to the Psychopathic Hospital for observation. Bridget's sister-in-law came to see her and told her that the family approved; the girl acquiesced readily. The social worker had no trouble with her on the way to the hospital. The authorities there were given the results of her investigation, and the case was left wholly to the physicians and social workers at that hospital.

Ten days later they sent a report saying that the patient had been committed to a hospital for the insane with a diagnosis of insanity and mental deficiency. The M.G.H. social worker gave this report to the other agencies who had known the family. The child-placing agency replied that the information would be applied in planning for the baby of whom they were taking charge.

COMMENT

This case, not in itself particularly interesting, is presented because it illustrates the importance of symptoms of social disorder, such as attempts at suicide, as an indication of mental disorder. It shows, too, the kind of work that has frequently to be done on cases from the Emergency Ward where the patient's stay is limited by routine to twenty-four hours.

E. W.

From the point of view of anyone interested in avoiding serious blunders in hospital routine, disastrous mistakes in diagnosis as in this case, the story is of great importance. Like Case 30 it illustrates one of the more baffling of the mistakes that not infrequently happen in general hospitals intended for the care of bodily but not of mental disease. Such people ordinarily know and complain that they are sick. But insane people rarely know that they are insane and still more rarely mention it. Hence, when they come to a hospital for some obvious malady like uterine tumor or iodine poisoning or for obscure symptoms like headache or backache, the hospital physicians (especially the less experienced internes)

often fail altogether to think of the possibility of insanity or to investigate it at all. I remember patients who have been elaborately examined and X-rayed for supposed stomach disease, for disease of the spine, etc., because all they complained of was certain pains, when insanity was the true diagnosis.

In this case the social worker suspected insanity and obtained the history which strongly suggested it, although the interne had apparently not thought of it at all. There is no class of patients who more often need the help of social workers in getting a diagnosis and the treatment appropriate than the insane: for the data for diagnosis in insanity are often largely *social* data — i.e., the behavior of the patient not before the doctor, but at home, at work, at school, in church, among acquaintances and friends. This the patient does not reveal to the doctor in whose presence he often 'pulls himself together' astonishingly. And if he comes to the hospital alone, there is no one else to complete the story. He does not mean to deceive, but we are deceived.

The remedy is to insist, whenever we can, on seeing the friends of any patient with obscure symptoms, with suicidal history or depressed aspect, to train our medical students more thoroughly in the mental diseases and the mental aspects of bodily disease. At the present time students get practically no training worth the name in these branches and have to pick up what they can after they get into practice at their patients' expense.

R. C. C.

CASE 36

MABEL WADSWORTH Age 20 *Single*

Admitted to ward June 21, 1917. Discharged July 5, 1917.

MEDICAL SOCIAL PROBLEM

Visceroptosis; feeble-mindedness; psychasthenia, broken home; intemperate father; worry and depression.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Visceroptosis; psychasthenia; suicidal ideas; mild depression. Psychological examination gives mental age as only eleven to twelve years, implying, of course, that she will never be any older intellectually

b. *Prognosis:*
Doubtful if much improvement can be brought about.

c. *Treatment:*
Extended convalescent care followed by suitable work, patient to be under observation at M.G.H. Neurological Clinic and have close supervision by Social Service.

d. *Additional medical history secured by social worker:*
Alcoholic heredity.

Social
(Family and patient)

a. *Analysis:*
Parents both native Americans of English stock; Roman Catholics. Family life has been unhappy owing to father's habits of intoxication and desertion. Mother has had hard struggle to support children; has been aided by Overseers of Public Welfare; S.P.C.C. active at one time. Patient has had to work from early age. For past two years father's whereabouts have been unknown. Father contributes nothing to family support. Mother earns $6 a week; patient $8 a week; rent is $10 a month. No legal settlement, as father wanders continually. Family have been residents of Lynn for over ten years. Mother and brother are well; father's condition unknown. Mother has very little education; no data obtained on father. Brother aged eleven is in grammar school; no data on progress. Patient left school in middle of eighth grade, writes a good hand, uses fair English, speaks correctly and without slang. Mother is a saleswoman. Pa-

Medical
(Patient only)

Social
(Family and patient)

tient has been a mother's helper from age of sixteen; recently entered a cracker factory as packer; does not like either kind of work. Father is a drunkard, abusive, utterly selfish; has made life miserable for family, who are glad he has deserted. Mother is a hard-working woman who has struggled to give her children a decent home and at least an elementary education; is much loved by her children. Brother seems to be an average child who gives no significant trouble. Patient is reserved, rather shy, apparently sweet-tempered, but bitter toward father; worries a great deal over present family situation and broods over past unhappiness; eager to work, but lacks confidence and initiative; is easily discouraged.

b. *Treatment:*

1. *Plan:* Supervision; convalescent care; secure suitable work.
2. *Results:* Patient much improved by convalescent care; suitable work secured; mental hygiene improved; supervision given over twenty-one months; thereafter occasional friendly and professional contacts over six years. Patient has held same job; earnings increased to $20 a week; loves her work, is thoroughly happy, and apparently admirably adjusted. Has gained in weight; general health much improved.

c. *Sources of information:*
Social agencies.

2. Therapeutic Assets

Medical

a. *Hospital clinic:* Will treat.
b. *Nursing home:* Too expensive.
c. *Convalescent home:* Available.

Social

a. *Family and patient:* Family can give no assistance other than sympathy and encouragement. Patient must change her mental attitude in order to benefit by treatment; is intelligent and well disposed about this. Home is a tenement of four rooms; not suitable for convalescence; neat but poorly furnished; neighborhood noisy and congested.
b. *Relatives:* There are no relatives able to help in any way.
c. *Private agencies and institutions:* Are available.
d. *Public agencies and institutions:* Are not needed.

NARRATIVE

Mabel Wadsworth was ready for discharge when the doctor, having decided that, after all, she ought not to go home, brought her to Miss Shaw's attention. She needed to be built up, he said, and ought to be in an environment where she would be contented and happy. Later, she would be able to go back to work if something could be found for her that she would enjoy doing. Her previous job of packing crackers in a factory was too uninteresting for her.

Going immediately to the ward to talk with Mabel, Miss Shaw found a delicate, attractive girl with big grey eyes, fluffy hair, good complexion, and pleasant manner. Though reserved at first, she told her story gradually, revealing the typical home of the drunkard's family. Because of the father's abuse of the children, the Society for the Prevention of Cruelty to Children had been active; four times they had had him arrested and he had served sentence in jail. From time to time the Overseers of Public Welfare had supported the family; but it was the mother's courage and devotion which had held them together and pulled them through to this point.

Miss Shaw secured, by telephone, admission for the girl at a convalescent home in the country, sending the written application by mail later. Mabel went out there willingly that afternoon. She spent five happy weeks there, much better in every way excepting that upon two occasions emotional strain and fatigue brought on attacks of an hysterical nature during which she seemed to lose consciousness.

After her return home, Miss Shaw helped her look for work which should be pleasant, not too fatiguing, and sufficiently remunerative. This was not easy to find, and after she had followed up several openings which did not lead to anything, Mabel became sadly discouraged. At the end of two weeks she went back to the cracker factory. A day or two later, Miss Shaw heard of a position which seemed desirable, but Mabel felt that her employer had been so good about taking her back that she ought to stay at the cracker factory for the present. She remained steadily at work for about two months, when she was taken ill and was sent to the hospital in her home town.

Her illness was diagnosed as broncho-pneumonia. She was in the hospital for six weeks. A few weeks after her return home, she reported, in accordance with her schedule, to the clinic at the M.G.H. Although there were no definite signs of anything wrong with her lungs, the doctor who saw her thought she 'needed convalescent care,' as her general condition was not good. Mabel was willing to go to another convalescent home recommended by Miss Shaw, but she begged off for a few days because she wanted to go to a party — and a party was a great event in her eyes. Miss Shaw, believing the party a valuable therapeutic measure, accordingly arranged for Mabel's admission to the convalescent home a week later. Meanwhile, Miss Shaw enlisted private interest to the extent of the amount of the rent and a stock of coal and groceries for Mrs. Wadsworth, so that Mabel need not worry about her family in her absence.

Mabel had her party, then went to the excellent convales-

cent home, where four weeks worked wonders for her both physically and mentally. Everyone there liked her and this gave her a certain confidence in herself. Before she left, she had become so energetic that she helped with the daily work of caring for the rooms.

Again, after her return home, Miss Shaw took up with her the matter of work. Within a short time an employment agency, to which she had made the situation clear, placed Mabel in the office of a firm dealing in office supplies. She was paid eight dollars a week, and worked from nine until five, with an hour for luncheon. Her duties were well within both her physical and mental capacity: she kept the office in order, answered the telephone, met visitors who came in, and attended to various small details, her duties increasing as she demonstrated her ability to handle what she had. She delighted in the variety that prevented her being bored, she enjoyed meeting people, and was stimulated by feeling herself of importance to others.

Soon after Mabel took this position, the case record was closed. For six years, however, the girl continued to report to the Hospital at intervals, and Miss Warren, Miss Shaw's successor, looked after her at such times. On the whole, Mabel's health was good. She put on weight, her outlook became cheerful, and she seemed contented with her life both at the office and at home, at work and at play. Her salary rose steadily until it reached twenty dollars a week, due to her faithful, efficient service. It will probably go no higher, though she has made herself so valuable to her employer that a further increase is not impossible.

Mabel makes an excellent impression. She dresses in good taste, has developed a certain poise, and has acquired from her associates (as many an eleven-year-old child may do) an amazing amount of superficial information which she uses with good effect. It is noteworthy that a doctor who has not seen her hitherto learns her mental age with astonishment, although upon closer acquaintance he cannot question the es-

sential correctness of the mental examination. So far as Miss Warren can see, Mabel is likely to go on indefinitely in the course marked out for her by long habit — a safeguard of those whose intellectual equipment is meagre.

COMMENT

This case illustrates the need of skilful work on the social as well as on the medical side of a problem where the patient is abnormal as to mental age. In such cases almost everything depends on the formation of steady habits, which, once fixed, hold the patient firmly to a safe course. Good health, pride of achievement, freedom from worry, complete satisfaction with home and work, together with lack of initiative for striking out alone; — all these are anchors for Mabel. And even if they should drag and force her to run before the storm, she knows of a safe harbor and would doubtless put into it for refitting.

E. W.

Low position of the abdominal organs (visceroptosis) is a matter about which it is in some medical circles the fashion to make a great fuss, especially when one can find nothing else wrong in a patient's anatomy. In most cases (as in this one) it is of no importance, and is soon forgotten by everyone including the doctors as soon as a more obvious diagnosis appears or as soon as the patient is too busy and fat to complain.

I doubt whether the monotony of this patient's job as a cracker packer was an important factor in her troubles. If other conditions had been right, she would have got along, as many others have, despite the monotony.

The prescription of convalescent care and rest is a favorite one in these cases — cases, I mean, whose troubles are mainly psychical — and rarely does any permanent good. It pleases the patient and gets her out of sight for a time. If the persons in charge of the home are willing and able to undertake the hard but essential task of changing the patient's mental atti-

tude and mental habits, great good may result during or in spite of the rest. Better habits of eating and sleeping and so better nutrition (with its by-effects on character) may be built up, as apparently they were in this case.

But ordinarily the 'therapeutic effects of a party' (and its results) and of conditions in which one may 'feel one's self of importance to others' are better treatment.

R. C. C.

CASE 37

MARGARET KELLEY Age 75 *Single*

Admitted to the Emergency Ward August 12, 1922. Discharged from the Emergency Ward August 13, 1922.

MEDICAL SOCIAL PROBLEM

Arterio-sclerosis and senility in an old woman without family ties; dependent on public relief.

1. MEDICAL SOCIAL DATA

Medical
(Patient only)

a. *Diagnosis:*
Arterio-sclerosis and senility; general decrepitude of extreme old age.

b. *Prognosis:*
Advanced age makes any improvement doubtful.

c. *Treatment:*
Unless patient has a good home she should have institutional care. No other recommendations.

d. *Additional medical history secured by social worker:*
Patient was in a tuberculosis sanatorium about fourteen years ago.

Social
(Family and patient)

a. *Analysis:*
Family of Roman Catholic, Irish stock. No reliable information obtained *re* family. Patient claims to have had very interesting career, but this cannot be verified. Probably born in Boston in 1848. Legal settlement in Boston. Education equivalent to public grammar school. Has worked as domestic servant and practical nurse. She is very friendly, amiable, with a distinctly altruistic outlook on life. Although supported for years by public aid, she has a strong sense of self-respect and is not pauperized.

b. *Treatment:*
Institutional care if possible.

c. *Sources of information:*
Other social agencies; M.G.H. employees' index.

2. THERAPEUTIC ASSETS

Medical

a. *L.M.D.*: District doctor may be called in at any time.

b. *Hospitals:* Chronic Hospital of

Social

a. *Family and patient:* No family. Patient has courage, optimism, makes friends easily.

Medical	*Social*
City of Boston is available and suitable.	b. *Relatives:* No known relatives.
c. *Nursing homes:* Would be admirable, but are too expensive.	c. No *benevolent individual* interested.
d. *Convalescent homes:* Not suitable.	d. Numerous *private institutions and agencies* know patient.
e. *District nurse:* Not needed.	e. *Public relief agency* is supporting her and will give institutional care if patient will accept it.

NARRATIVE

LATE one summer afternoon, one of the visiting physicians spoke to me of Miss Margaret Kelley, an old woman who had come that day to our Emergency Ward. She could not, he said, be admitted to our Hospital, which is for treatment of brief or acute illness; but he would keep her in the ward overnight, relying upon me to make suitable plans for her after that. What the woman apparently needed was the sort of care that more fortunate old persons receive as a matter of course in their own homes or in those of their children; but she had said she had no relatives or friends and not much money. He would leave her in my hands.

It was so late that I didn't want to talk to the patient that day lest her night's rest be disturbed; but I made sure that things were all right with her by calling up the Head Nurse, who reported that Miss Kelley was eating supper with evident enjoyment and was quite at her ease. Next morning I went in to see her, introducing myself as the social worker to whom the doctor had entrusted the responsibility of helping her about going away from the Hospital; and I congratulated her because she had not to remain in the ward on such a heavenly summer day. Miss Kelley responded affably and entered into the planning heartily. She said she thought I ought to know more about her in order to help me decide what would be suitable for her, and so volunteered to tell me something of her history if I had time to listen. I shook up her pillows and smoothed the bed covers and drew up a chair to the bedside. She urged me to take notes of the important facts she would

divulge, unless I had a good memory. Her own memory was remarkable; but she had learned from experience that few persons had anything like it.

I produced a notebook and she began. Her weak, cracked, but pleasing old Irish voice rambled on and on. Items were related, recorded by command in the notebook, then changed from time to time after further search in the memory of which she was so proud. Gradually, however, outlines emerged of what might be considered history rather than myth. Her parents, Mr. and Mrs. Robert Kelley, had lived in a substantial house in a good section of Boston when their daughter Margaret was born, somewhere between seventy and eighty-five years ago — the exact date was immaterial. Mr. Kelley was a successful merchant and a prominent citizen and all their relatives were prosperous. But though life was gay and pleasant, Margaret was always aware of the misery and suffering in the world about her, and longed to do something to alleviate it. When she was seventeen, although her family objected seriously, she insisted upon entering the M.G.H. to train as a nurse. For six years she nursed in the Hospital, leaving to take care of the mother of 'one of the leading doctors on the staff.' For nine years she remained with this family, going to Europe with them on more than one occasion.

As the years passed, Margaret's relatives died, leaving money to her which she deposited in a certain private bank which paid a high rate of interest. She was warned against the bank as not being safe; but she wanted a great deal of money to give to the poor and so she held to her choice. It failed, however, and she lost every penny she had on deposit — some $9500. This was a terrible blow, as it curtailed her charitable activities, but it taught her caution in money matters.

During the Civil War, Margaret married a man whose name was the same as her father's, though he was not related. They were married in New York State and shortly afterwards her husband enlisted in a Massachusetts Cavalry Regiment. He

was killed on a battle-field whose name she had long since forgotten. His body was never found. For this reason she was told she would have great difficulty in getting a pension and had therefore never applied for one.

She turned to nursing to support herself, working in several of 'the most distinguished families of Boston.' With great self-denial she managed to save nine hundred dollars which she carried around on her person for years, fearing to trust any bank with it. Soon after the World War she invested it in a Get-Rich-Quick scheme and it was swept away. Eventually, she had to accept public aid, though she could not recall how it came about. She felt keenly the social stigma upon one of good family, but she could not avoid it. Her only living relatives were two nieces in California who were well-to-do. They visited Massachusetts occasionally and were always eager to see her. She was anticipating a visit from them about this time.

When she had reached this point in her story, Miss Kelley — or Mrs. Kelley, as she asked me to call her now that I knew of her marriage — seemed tired, and I suggested that she take a nap after which I would see her again. She was quite ready to do so.

I used the time to attempt to verify her story. There was no record of an employee of her name at the Hospital; her account of having *graduated* at the Training School and having been a nurse here could not be true because she placed her training at a period when the school had not been organized. She might have been one of the attendants employed prior to the coming of the trained nurse; on the other hand, her familiarity with the names of so many of the physicians and surgeons on the staff in the sixties might have been acquired if she had been a patient at the Hospital. However, her name was not to be found in the old medical records.

My next step, to inquire of other social agencies who might have known the patient, was more successful. There was scarcely a social agency in Boston that hadn't at one time or

another known her. All had approximately the same story of her, but none had been able to verify it. There were no means of proving that she had been born in Boston, as her birth had apparently occurred before such statistics were kept. Her marriage was generally considered a figment of her imagination. Her financial disasters, however, were founded on fact so far as that the bank she had named had failed and the Get-Rich-Quick scheme had landed in the courts; and her dependence on public aid for many years was beyond question. At one time she had been thought to be suffering from tuberculosis and had been sent to a sanatorium by the Overseers of Public Welfare. There were no known relatives, although Miss Kelley had given the names of a number. It was noted that she used the same name for her father, her husband, and a nephew who, she said, lived in another New England city. Her story of her connection with the M.G.H. was prompted, apparently, by her desire to sample our treatment, as we were the only hospital in the city so far unknown to her. On the strength of that fictitious connection, a dispensary which thought hospital care advisable sent her to the M.G.H.

The Overseer of Public Welfare, who was responsible for Miss Kelley, instructed me to send her to the city's Hospital for Chronic Cases if she would go. Otherwise she would have to return home and he would again assume full responsibility for her. He understood that if her condition had warranted it, she would have had free treatment at the Hospital; but a hospital for acute cases was not the place for her.

Returning to the ward, I told Miss Kelley that it seemed best for her to go for a time to a hospital for chronic diseases; but she calmly refused to do any such thing. Apparently she had no recollection of the story she had told me that morning. Beginning again, she told me that she had worked here when she was thirteen years old, and that her husband had been killed 'about twenty years ago in the Civil War.' In fact, she skipped blithely about through the past half-century showing absolutely no sense of time. She was amenable to all my other

suggestions except that of entering a hospital for chronic diseases. On the contrary, she felt constrained to hurry home, as her nieces from California might have already arrived for their visit.

The nurse dressed the plucky old woman, and, greatly to my surprise, she seemed to lose her feebleness and gain strength in proportion to the clothes she put on, so that when she was fully clothed, she appeared a sprightly old lady all ready to enjoy the trip home in a taxi. I accompanied her and went with her to her two rooms up one flight of stairs in a house which had once been a family residence, but now sheltered several families. The rooms were furnished with all she would need, but with no extras, and were clean, though not orderly. Safely back again, Miss Kelley felt impelled to call at once on her neighbors, and I left her ensconced in a chair in their kitchen, eager to begin upon her adventures.

Not quite at ease to have left her there alone, I telephoned the Overseer and told him I had followed his instructions and placed the patient in her home. He promised to look in on her later, but told me I need not feel troubled. He had seen Miss Kelley many a time when she had seemed so feeble as to be able to go on no longer, only to find her restored to her usual vigor within a short time.

Hanging up the receiver, I looked at the clock and at the calendar. It was a fact that within the space of four hours of social work on that day, and one hour of medical work on the preceding, with the intervening hours filled with nursing, the M.G.H. had done all it could for Margaret Kelley. And yet, it seemed as if I had known her for years!

Some three months later, another hospital social worker telephoned me about Miss Kelley. She had been referred to her by the Superintendent there. It was feared that she was suffering great privation. It appeared that for over fifteen years she had been availing herself of medical treatment at this hospital, although no social worker had heretofore known her. I gave my colleague the substance of my record and she said

she would, of course, communicate at once with the Overseer of Public Welfare. Nine months later, a relief agency inquired about the patient. Evidently her catholicity of taste was still supreme, likewise her kindly spirit, for she is the last person in the world to hurt any agency's feelings by neglecting to patronize it. Boston has many agencies, so there is no reason to fear a shortage of material for Miss Kelley's charitable activities.

COMMENT

This case illustrates the sort of proceeding that puts a great deal of pressure on our Emergency Ward. Some well-meaning person examines a patient and decides that hospital care is needed. Possibly this person is not capable of distinguishing between care in a hospital for chronic cases and one for acute illnesses; possibly he does not know that there is such a distinction; possibly he is only desirous of getting the burden off his own shoulders and on those of someone else. In any event, many patients are sent in with such vague symptoms that they are allowed to pass no further than our Emergency Ward, and the Social Service Department is asked to arrange for care for them in some other place. Such work has to be done quickly, as the stay of such patients in the Emergency Ward is limited to twenty-four hours. Many times the patients are subjected to needless discomfort by being sent here; they are bewildered and hurt because they are not admitted; and would have been spared much if whoever had sent them had first ascertained whether they were suitable cases for a hospital for acute illness.

E. W.

PART III

GENERAL COMMENTS

GENERAL COMMENTS

BY R. C. CABOT

Section 1. The Group of Cases Studied Here

It should be acknowledged at the outset that this book describes mainly one type of social work, though one of the most important, namely, that *concerned with patients in a hospital ward.* Work with 'out patients' (that is, with those who come for advice and treatment, but go home the same day and are not fed or housed in the Hospital) is different in most of its typical problems from what this book describes and illustrates. Moreover, social work in the wards of a hospital for children, for obstetrics, for the insane, for the tuberculous, for chronic disease, is in each case distinctly different from that done at a hospital like the Massachusetts General which cares for acute (that is, brief) illnesses, medical or surgical, refusing most cases of chronic disease, of contagious disease, and of insanity.

In another respect the work here described is peculiar; it is done in a city and in a State well supplied with medical institutions and charitable agencies of many kinds. If one had to deal with patients just like those here described, but in a city with few social and medical resources, one's work would be quite different.

Thirdly, these medical-social case histories are unlike many others in that few of the patients belong to the impoverished, down-and-out strata of society. We are not dealing here with the 'submerged tenth' of our city population. Our patients are not rich, but until the extra demands of illness were added, most of our ward patients were getting along in fair comfort economically. Workers attached to hospitals for the very poor will be surprised at the average economic status of our ward patients.

Section 2. How the Efforts of Physicians are Stimulated by the Fact that Social Workers are at Hand to Help

Many hospital physicians get discouraged and superficial in their work because they know that no substantial or permanent good can come of their efforts for accurate diagnosis and intelligent prescription. They know that their instructions are not likely to be carried out when their patients leave the ward, and that the drag of poverty, ignorance, and neglect is apt to undo whatever good may have been accomplished by their efforts. But with adequate help in the instruction and persuasion of patients and of their families, in the following-up of treatment until results are accomplished in the modification of bad hygiene, domestic, industrial, and psychical environments and the re-education of parents — a doctor comes to feel that his best efforts are worth while and are appreciated.

The presence of independent interest in his patients maintained by someone not, like the nurse, directly under his orders nor tacitly pledged to excuse and defend his treatment in all respects, has likewise a stimulating and helpful effect upon hospital physicians. Someone representing the community and the interests outside medicine and surgery is working with him, ready with appreciation and independent suggestion. The presence of trained nurses elevates a physician's standards, as will be vouched for by anyone who has seen for comparison the medical work carried on without trained nurses in the American Army hospitals during the Spanish War or in the French hospitals of to-day. But the presence of social workers helps the doctor's standards in other directions.

A still further advance would, I think, be seen in the medical and surgical work of our hospitals were well-trained psychologists, physiologists, and ministers of religion in close touch with the welfare of hospital patients. All these professions can be benefited by 'clinical' experience and can give help in their turn.

There is at present all too little attempt to get the clergy and students of divinity into our hospital wards. Like medical students they can do harm, learn little, and contribute less if not properly supervised. But like the medical students, the clergy could attain to a position of great usefulness, indeed indispensability in our hospitals, if their position and duties there were worked out as carefully as we have done with medical students. Nurses and social workers were both resented when they first tried to assist and supplement the physicians' work at the Massachusetts General Hospital. Both groups had to force their way in against the indifference or the hostility of the staff as a whole, though with the help of individual members of it. Psychologists, physiologists, and ministers of religion will have to face the same indifference or opposition, but I hope they will not thereby be deterred from working their way into hospital wards, for they belong there and their work is not as yet being done.

Section 3. These Cases as Fair Samples of Human Misfortune

Although in certain respects I believe that these cases and the treatment of them belongs to a special group and are not typical of the problems of the illness at large, in other respects they seem to me to teach lessons applicable not only to all types of social work, but to all attempts to deal with people in trouble of any sort. The way that the problem as it first presents itself widens, deepens and is complicated with our increase of understanding and with the lapsed time, is characteristic and instructive I believe in all types of misfortune. The part played by the unforeseeable both in producing and assuaging the forms of distress here described is what we have to learn in all fields of human endeavor against evil. Many more such characteristics could be identified in these cases.

Section 4. Medical-Social Work Opens a Possibility of Getting at Those who Most Need Aid but will not or Cannot Ask it

As one reads through Miss Wulkop's cases, we repeatedly find the workers 'picking up' patients and clients who had not thought of asking anyone's aid. Ordinarily in medical and in social work we take the passive attitude. We wait for those who need us to call for our aid, wait in offices or hospitals. But it takes little experience to teach us that those who actually seek our help are not 'the sick' or 'the poor,' but *that fraction of the sick and the poor* who know of our existence and have the will and the power to come. No one knows or can find out whether this fraction is a large or a small part of the whole number, a characteristic sample or a specially selected group. We are always prone to forget that we are dealing only with such possibly unrepresentative fractions. Much that is written about tuberculosis is quite misleading, because it describes only the cases which are known during life to doctors or to the patients themselves, and ignores the far larger number of cases, discovered only at the post-mortem or not at all, because they were healed by 'nature' and never presented any recognizable symptoms.

We have begun to recognize that 'the unemployed' as they march in procession may represent a considerable percentage of the unemployable, or of the 'professionally unemployed,' while many others just as badly off, but less vocal, escape our notice.

So with the physically handicapped. Unless we make a house-to-house canvass, as was done in the Cleveland Survey, the group that present themselves at an agency organized to help may represent the more vocal and plangent fraction and often those hardest to help, not the whole number, not those most capable of being aided.

So we write rash volumes about 'the criminal' or the unchaste woman, forgetting that our knowledge is based only on the certainly small and probably unrepresentative *fraction*

who get caught because they have not the skill or luck to escape detection.

Now the social worker is frequently in the way to discover patients who never would have consulted a doctor or be known to suffer until perhaps it is too late to help them. She may discover the silent sufferers who will not complain, the poor who starve themselves as the man described in Case 33 did, but will not ask help. We sometimes fancy that those who ask help most urgently and complain of their sufferings most loudly are those who suffer least. At any rate, everyone must desire poignantly to help those who suffer in silence. Medical-social workers pushing on into the ramifications of a patient's family and friends are sometimes fortunate enough to find and to help those peculiarly needing it.

Section 5. Recording One's Impressions of Character — Is it Good Practice?

These social workers' descriptions of character are extraordinarily full and definite, considering their limited time and opportunities for observation. It is worth while to run through the analysis at the head of each case. They are, of course, to be considered as impressions rather than fixed conclusions. But nevertheless action is based upon them to some extent. Should they be thus definitely expressed when they must be as subject to error and modification as is obviously the case here?

The best answer seems to me to be that everyone has his impressions of character after he has had the sort of frank and detailed conversations which one can — indeed must — have with a patient who in a critical period of his life confides a considerable portion of his welfare to one's care. In a picture of the patient's situation, such as the writer of these records aims to give, it is right, I think, to get down the impression which actually formed part of the body of data in framing a plan for the patient, admitting that they are all subject to correction in the light of fuller knowledge.

Personally I believe that these diagnoses of character are likely to have proved helpful in the long run, because in so large a proportion of them admiration plays a part. One notices with some surprise as one reads this book that, although there seems to be no selection of cases, although they seem to come to the worker's attention as chance samples of sick human beings of all races, of various ages, of both sexes and out of every sort of background, nevertheless the most of them turn out to be an uncommonly good sort. In twenty-six out of thirty-seven cases this seems to be the case. My own experience in dealing with the sick is altogether in harmony with this. Cut the pack and turn up any card. In sickness, when you come to a person with an intelligent and persistent desire to be of service, you generally turn up some fine character. It appears under this particular set of conditions uncommonly often. It is there more or less latent at other times. We have the good fortune to approach from an angle and in a crisis that brings good qualities to light. Under other conditions, in laziness, in casual acquaintance, people often turn their worst sides to the light. In sickness they usually give their best to him or her who comes with a single-minded desire to help.

Therefore, I believe that the favorable estimates recorded in twenty-six of these cases represent the most important and utilizable portion of the truth, though not the whole truth, and that the worker's ability to form them was a large factor in her success.

Section 6. Preventing the Development of Neurotic Symptoms in Actual or Suspected Heart Disease

In several cases of the section on heart disease, Miss Wulkop mentions the efforts referred to above. They are most important, not only in heart disease, but in many other fields of medicine, and medical-social workers (together with sensible and well-informed people generally) must take an active hand. What I mean is this:

There is a great deal of disease — mostly of the neurotic type — actually produced by contact with doctors, nurses, hospitals, and the phrases and suggestions that come to the patient from their sources. To have one's heart thoroughly examined and its possible deficiencies explained is a most important duty for many. But nevertheless it can hardly help making a person vividly conscious of his heart or of sensations in that part of his body supposed to be due to the heart. This is the beginning of disease — of neurosis, for we are so made that the fixation of our attention on the heart, the stomach, or any other organ which is meant to act without our being conscious of it, at once upsets us in various ways. Certain words and suggestions make a wound in our nervous systems that must be very slow to heal. The isolation and introspection often necessitated in carrying out medical advice are inevitable, but definitely harmful and must be neutralized and attacked by vigorous effort. This effort is all along the line of minimizing the harm of medical information by giving more medical information. Having learned that we have a heart, we must learn how to forget it. Having been told to be careful, we must further learn how *not* to be full of cares. Having been given reasons for looking after ourselves, we must learn not to look after ourselves, but to forget ourselves most of the time.

In the better sanitaria for nervous troubles, patients are forbidden to talk to each other about their symptoms. But in hospital work we often fail to tell the friends and relatives of patients not to talk to them or let them talk about disease.

For even in serious organic disease the patient's worst sufferings are often due, not to the disease at all, but to his fears and worries with the bodily disturbances which they set up. He may be able to get along very happily despite an incurable disease if he can be taught not to add a great weight of neurotic symptoms on top of it as a result of thinking, wondering, and introspection. Quacks often reap a rich harvest by capitalizing their knowledge of this most unavoidable human

failing. They persuade the patient that they can cure his incurable disease and thus get him so encouraged that he forgets for a time to think of himself and begins to feel immensely better.

Honest helpers must try to accomplish the same result by getting a patient to work — to play, to love his friends and family, and to worship God in spite of and in forgetfulness of his disease — when once certain new habits have been formed.

Doctors and nurses know this perfectly well, but they seldom act effectually on their knowledge. The poisonousness of a medical atmosphere and medical associations they easily forget. It is, therefore, especially the social worker's job to supplement the doctor and the nurse at this point, carrying into effect what they would on occasion preach, but ordinarily forget to practise.

Section 7. Convalescent Care and Convalescent Homes

It is often and truly said that doctors and nurses lose interest in their patients when the critical days are over and convalescence begins. But it is not so often noticed that there is a good reason for this, namely, that in convalescence there is very little that most doctors and nurses know enough to do. They don't want to pretend that they are needed and that they see work cut out for them in convalescence, when the truth lies in the opposite direction.

In acute stages of appendicitis or diphtheria we know what to do (as a rule). In their convalescence we do not. Nature is doing this work and will do it no better if we stand assiduously by. Research is needed here before the ordinary doctor and nurse will have any definite business in convalescence. When we know more about how to promote the repair of tissue and the absorption of disease, we may be as busy in convalescence as before it.

Most that we do know about convalescence leads us to an endeavor to get patients away from doctors, nurses, hospitals,

medicines, and splints and '*back to Nature*' as soon and as far as possible. To make the convalescent forget that he has been sick, to get new and healthy experiences of sight, sound, smell, and taste into him, to get him away from other sick people and from the memories and suggestions of disease, we must separate him as soon and as thoroughly as we can from doctors, nurses, and the rest of medical paraphernalia.

Therefore I 'view with alarm' the fact that enormous funds are now becoming available, not so much for the impartial study of convalescence as for the building of institutions where patients, doctors, and nurses will in all human probability soon be congregated, when (as I said) the prime need is to separate the convalescent from other convalescents and from the traditions and associations of medicine.

We are gradually learning that weakened and stiffened muscles can best be restored in Nature's way; that is, by using them, rather than by electrical stimulation, by massage or by passive motion. These latter have their chief use when the patient cannot use them himself or to encourage him to do so. But more than that, use for the sake of use is not as good as use to accomplish something that we really want to do. Gymnastic exercises and walks taken as 'constitutionals' are less healing and valuable than games or industrial work accomplishing in some way what we want to do and moving our muscles, as the healthy man does, without knowing that he has any.

Taking this as the model, we must try to make all convalescence as natural, as non-medical, as much like ordinary life as we can, to get the individual back into family life, into his ordinary enjoyments and duties as soon as we can.

Medical men and those under their influence are the last people in the world to do this. To ask it of them is like asking a mourner to crack jokes or a *bon vivant* to camp out. All his habits and instincts are against his success.

Yet who but doctors are now in charge or are likely in future to be in charge of convalescents and convalescent

homes? Moreover, it is clear, of course, that doctors are always going to be needed by the convalescent because he may at any time relapse into acute illness or need expert advice on his progress and his limits.

It is easy to build institutions for convalescents and will be hard if not impossible to get men fit to care for the patients in them, unwarped by our age's prejudice for soul-enslaving devices like 'physical therapeutics' and tepid routines of rest for the massing of individuals in unmanageable groups.

Medical foster-homes (see Case 3) *can be made*, I believe, the best supplements to the patient's own home. There we can have family life and work with more expert watching of the convalescent's needs than is often available in his own. Would that the millions of dollars sure soon to be sunk in huge buildings and 'physical therapy' for the convalescent might go into the discovery and maintenance of a group of medical foster-homes various as the needs of convalescents from the various diseases, providing expert guidance of mind and spirit which dominates the sound rebuilding of the body!

Section 8. Significant Silences in Social Work

The habit of doing one's daily work in response to *calls* is deeply ingrained in doctors and in social workers. Clients ask for help, bad conditions in a family are reported, the telephone rings, letters and messages come in and our activities are set in motion.

But it does not follow, unfortunately, that if a patient does not call there is nothing for us to do. No news may be bad news, as in several of the cases of this book. The boy who falls from an apple tree and howls is probably not very seriously hurt, but the boy who falls and does not howl may be very badly off. Yet he may not attract any rescuing attention. So in social work, the people who do not complain and the silent periods in the case of anyone who has earlier called for help may need our very particular activity, yet may in fact get nothing from us at all.

For, as I have said, our habits are so organized in medicine and in social work that we are very apt to forget and neglect people who do not make a noise. Sometimes, of course, no news in social work is good news, but there are so many exceptions that we must arrange some machinery for reminding us to inquire at regular intervals even when we hear nothing. In hospital wards this is provided for by regular visits of nurse, interne, and visiting physician so that the silent sufferer can be discerned. In out-patient medical work there is ordinarily no such provision, and the patient who doesn't come and is forgotten may be the one who needs us most. In some clinics we arrange a file so that the patient's name is *brought before our eyes* every few days or weeks and we can write inquiring for him if he does not appear on the day expected. But as a rule we do not 'look for trouble' or invite any extra work. Thus we sometimes invite disaster for the patient.

Regular letters of inquiry are the way out. In several of these cases they helped to avert trouble.

Section 9. Is there a Standard Social Technique?

One sees in reading these stories what an amazing and baffling variety of problems confront the worker and how immediate is the call for action in many of them. Much resource and acquaintance with the community's agencies for helpfulness is shown in the treatment worked out. Nevertheless, I believe that another group of workers with a different background and set of working principles would have proceeded very differently in many of these cases and very likely would have achieved as good results. The main point is the worker's intelligent and prolonged interest. Given that, the way to some tolerable solution may be felt out along any of the several different paths. For instance, a consistent and convinced socialist, a fervent and well-informed Catholic, a well-trained and sympathetic psychologist, might have balanced the different factors of appreciation and of decision

very differently and yet obtained by any dispassionate standard of approval as large a proportion of success.

For there are many ways — not one way only — of succeeding in medical-social work and the patient's own character is the largest factor in them all. Just so in medicine there are many plans of treatment used by different physicians for the same disease, and if the physician is intelligent, faithful, and well-used to his own particular method, its limitations and modifications, it will do as well as another, because the main deciding factors are not our plans of treatment, but the patient's constitution and the spirit of devotion in which we pursue our efforts, the forces of Nature, and the energy of intelligent good will with which we try to assist them.

GLOSSARY

Adenitis. Inflammation of a gland.
Adenocarcinoma. Carcinoma involving glands and marked by metastasis.
Adrenal. Near or upon the kidney.
Aneurysm. A blood-containing tumor connecting directly with an artery or formed by the enlargement of an artery.
Angina pectoris. A disease of the heart marked by severe constricting pain in the chest.
Anti-luetic. Anti-syphilitic.
Aorta. The main trunk of the systemic arterial system.
Aortic regurgitation. Backward flow of the blood through the aortic orifice.
Arterio-sclerosis. Hardening of the arteries.
Arthritis, infectious. Inflammation of one or more joints, due to an infection.
Ascites. Fluid in the peritoneal cavity.

Bronchiectasis. Dilatation of bronchial tubes.

Carcinoma. Cancer.
Cervical. Relating to any neck-like structure.
Chorea. A disorder usually of childhood, marked by involuntary movements of limbs or facial muscles. Commonly called St. Vitus's Dance.
Colitis. Inflammation of the mucous membrane of the colon; due to tuberculosis in some cases.

Dementia præcox. A mental disease.
Dementia præcox hebephrenic type. The more quiet form of dementia præcox.
Diabetes mellitus. A disease of metabolism; the common form of the disease.
Diagnosis. The determination of the nature of a disease.

Effusion. The escape of fluid from the blood-vessels or lymphatics into the tissue or a cavity.
Endocarditis. Inflammation of the endocardium or lining membrane of the heart.
Enteritis. Inflammation of the intestine.
Etiology. Causation of disease.
Exophthalmic goitre. A condition marked by prominence of the eyeballs, enlargement of the thyroid gland, tremor and rapid heart action.

Femur. Thigh-bone.
Fibroids of uterus. A benign tumor, composed of fibrous tissue, located in the uterus.

Gastrectomy. Excision of a part or all of the stomach.
Gastric. Relating to the stomach.

Hallux valgus. A deviation of the great toe toward the outer side of the foot.
Hilus. The part of an organ where the nerves and vessels enter and leave.
Hypernephroma. A malignant tumor composed of adrenal tissue.

Inguinal hernia. Rupture in the groin.
Insulin. A remedy for diabetes.

Laminectomy. Removal by surgery of one or more of the thin plates which cover the vertabræ.
Laryngeal. Relating to the larynx.
Lesion. A wound or injury; a more or less circumscribed pathological change in the tissues.
Ligation of tubes. Tying-off of the oviduct, producing sterility.

Malignancy. Denoting the characteristics of a new growth, as distinguished from one which is benign.
Manic-depressive insanity. A mental disease of very serious nature.
Metabolism. Tissue change; the sum of the chemical changes whereby the function of nutrition is effected.
M.B.R. A test in the study of metabolism.
Metastasis. The shifting of a disease or its local manifestation from one part of the body to another; in malignant diseases, the appearance of new growth in parts of the body remote from the seat of the primary tumor.
Miliary tuberculosis. Acute generalized tuberculosis.
Mitral stenosis. Narrowing of the mitral valve of the heart.

Nephrectomy. The operation of removing a kidney.
Nephritis. Inflammation of the kidneys.
Neurological. Pertaining to the branch of medical science which has to do with the nervous system and its disorders.
Neurosis. A nervous disease.
Neurotic. Nervous — relating to or pertaining to a neurosis.

Orthopedics. A branch of surgery which has to do with the treatment of chronic diseases of the joints and spine and the correction of deformities.
Osteogenic. Relating to osteogenesis, making bone.
Osteomyelitis. Inflammation of the bone-marrow.
Otitis media. Inflammation of the middle ear.

Paraplegia. Paralysis of the lower extremities and also of more or less of the trunk.
Pericarditis. Inflammation of the pericardium or membrane covering the heart.
Peritoneum. The serous sac lining the abdominal cavity and covering most of the viscera contained therein.
Peritonitis. Inflammation of the peritoneum.
Pertussis. Whooping-cough.
Pharmacopeia. A work containing a list of accepted drugs and establishing standards for their strength and purity together with directions for making preparations from them.
Phobia. An unreasonable or insane dread or fear.
Pleurisy. Inflammation of the pleura or membrane, enveloping the lungs.
Prognosis. The foretelling of the probable course of the disease.
Psoas. A cold abscess, the pus coming generally from tuberculous disease of the vertabræ.
Psoriasis. A skin disease.
Psychasthenia. A mild psychosis marked especially by lack of self-control, morbid fears and doubts.
Psychosis. A disorder of the mind, insanity.
Pulmonary. Relating to the lungs.
Pulsus alternans. A variation in size or force of the alternate pulse beats, the rhythm being unaltered.
Pyorrhea. A suppurative inflammation of the lining of the tooth sockets and gums.

Radius. The outer and shorter of the two bones of the forearm.
Renal. Relating to the kidneys.
Rheumatic heart disease. Valvular heart disease caused by rheumatic or other acute infection.
Rheumatism. An acute disease, probably infectious.

Sarcoma. A tumor, usually highly malignant, generally included under cancer in the popular use of the latter name.
Senility. The sum of the physical and mental changes occurring in advanced life.
Sinus. A hollow in bone or other tissue; a fistula or tract leading to a suppurating cavity.
Spastic. Spasmodic, convulsive.
Suppurative. Forming pus.
Symptomatology. The aggregate of symptoms of a disease.

Therapeutic abortion. The surgical interruption of a pregnancy because of the mother's ill health.
Therapy. The treatment of disease.
Thyrotoxicosis. Poisoning by an excess of thyroid secretion.
Tonsillectomy. The operation of removing the tonsils.

Trachoma. A contagious inflammation of the eye.
Traumatic. Relating to or caused by a wound or injury.

Ulna. The inner and larger of the two bones of the forearm.

Valvular heart disease. A condition due to injury to the cardiac valves which control the flow of blood through the heart. Generally caused by an acute infection, in childhood, by scarlet fever, rheumatism, tonsillitis, etc.
Visceroptosis. The falling of the abdominal organs from their normal position.

Wassermann reaction. (Known as W.R.) A diagnostic test for syphilis.

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Chronic skin disease (psoriasis); deep depression; unfavorable home conditions.

30. *Anna Hopkins:* æt. 36. 276
Benign tumor of uterus with mental disease; broken home; dependent on relatives.
31. *Dominic Petronio:* æt. 37. 282
Lobar pneumonia; no financial resources; public aid.
32. *Giovanni Tremuri:* æt. 34. 290
Exophthalmic goitre; insufficient income.
33. *Oscar Anderson:* æt. 62. 295
Fracture of thigh-bone and both bones of right forearm; no relatives or friends; no home; no money; workmen's compensation.
34. *Marietta Simpson:* æt. 71. 301
Fractured thigh-bone; old age without financial resources; institutional care.
35. *Bridget Grogan:* æt. 24. 306
Attempted suicide; widowhood; no home.
36. *Mabel Wadsworth:* æt. 20. 312
Feeble-mindedness; psychasthenia; suicidal ideas; broken home; successful readjustment in community.
37. *Margaret Kelley:* æt. 75. 319
Arterio-sclerosis; dependent old age.

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